STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455423	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCC AT VALLEY GRANDE	**901 WILDROSE LN BROWNSVILLE, TX 78520**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were treated with respect and dignity and care for each resident in a manner and in an environment, that promotes maintenance or enhancement of his or her quality of life, for one Resident (R#15) of six residents reviewed. R#15 was laying on bare plastic mattress with a sheet covering only the top half of his body. The lower part of R#15 was uncovered, exposing his bare legs and adult brief. R#15's privacy curtain and door were open. This failure could place residents at risk of feeling uncomfortable and disrespected and could decrease residents' self-esteem and/or quality of life. The findings were: Record review of R#15's medical record revealed R#15: -was admitted to the facility on [DATE], -had [DIAGNOSES REDACTED]. Record review of R#15's MDS assessment, dated 05/31/20, revealed R#15: -had severely impaired cognition, -was totally dependent on staff for bed mobility, dressing, eating, toilet use, and personal hygiene. Record review of R#15's Care Plan, dated 06/03/20 Care Plan revealed: Change position every 2 hours. Observation on 06/30/20 at 3:04 p.m. revealed R#15 lying in bed, on his side, facing the open door. The curtain was not drawn. R#15 was laying on bare plastic mattress with a sheet covering only the top half of his body. The lower part of R#15 was uncovered, exposing his bare legs and adult brief. R#15 did not answer surveyor's questions. Observation on 06/30/20 revealed all the residents' doors were open and all the curtains opened so residents could be viewed from the hallways for 11 residents on 100 Hall, 21 residents on 200 Hall, and 15 residents on 300 Hall. In an interview on 06/30/20 at 7:45 p.m., the Administrator stated that she would talk to staff concerning the curtains in the residents' rooms being pulled for privacy. Record review of the facility's undated policy titled, Resident Rights Policy CFR 483.10, revealed: Policy: The facility protects and promotes the rights of each resident admitted in order to provide a dignified existence, self-determination and communication with and access to persons and services inside and outside the facility. The facility will protect and promote the rights of each resident .
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observation, record review, and interview, the facility failed to ensure residents had a safe, clean, comfortable, and homelike environment, for three halls (100 COVID Hall, 200 Hall front warm, 300 Hall front warm) of three halls reviewed for environmental issues. 1) The 300 Hall front warm had three large grey trash cans, two dirty linen carts, one clean linen cart and biohazard bags along the walls of the hallway. 2) The 200 Hall front warm had three large grey trash cans, two dirty linen carts, two clean linen carts, two chairs, and three wheelchairs along the hall. 3) The 100 COVID Hall back had three large grey trash cans, two dirty linen carts, and one clean linen cart along the hall and five large biohazard bags stacked at the exit door. These failures could place residents at a safety risk, minimize resident independence, a feeling of being uncomfortable and being in an institutional environment versus a homelike environment. The findings were: Observation on 07/02/20 at 11:33 a.m. revealed the 300 Hall front warm had three large grey trash cans, two dirty linen carts, one clean linen cart and biohazard bags along the walls of the hallway. Observation on 07/02/2020 at 01:32 p.m. revealed 200 Hall front warm had three large grey trash cans, two dirty linen carts, two clean linen carts, two chairs, and three wheelchairs along the hall. There were biohazard bags on the hallway floor. Observation on 07/08/20 at 11:11 a.m. revealed 100 COVID Hall back had three large grey trash cans, two dirty linen carts, and one clean linen cart along the hall and five large biohazard bags stacked at the exit door. No housekeeping staff was seen. In an interview on 07/02/20 at 11:15 a.m., the Administrator said she would take care of the clutter. Record review of the facility's undated policy titled, Resident Rights, revealed: Policy: The facility protects and promotes the rights of each resident admitted in order to provide a dignified existence .
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good grooming and personal hygiene, for five residents (R #3, R#9, R#10, R#15, R#16) out of five reviewed with complaints of ADLs not being completed. 1.The facility did not provide shaving and adequate grooming and personal hygiene for R#9 and R#10. 2. The facility did not provide bathing on scheduled days for R#3, R#9, R#10, and R#16. This failure could place residents at risk for not receiving adequate care and services to maintain their ability to perform Activities of Daily Living (ADLs). Findings included: 06/30/2020 at 02:54 PM Interview with R#9. R#9 stated that he had not had a shower or shave in 4 days.(NAME)stubble showed on his face. 06/30/2020 at 02:58 PM Interview with R#10. R#10 was sitting in his wheelchair weeping. R#10 stated that he was a veteran and shouldn't be treated this way. R#10 stated that he had not had a shower or a shave in 4 days. R#10 showed facial hair growth looking unkempt. 06/30/2020 at 03:01 PM Interview with R#16. R#16 was calling out to Surveyor to come in to her room to talk to her. R#16 was laying on her back in bed with slight incline to head of bed. R#16 stated that she had a sacral pressure ulcer and no one had done her wound care for 3 days. She stated that she could not turn herself and now she only gets turned maybe two or three times a day. She stated that the food is always cold. R#16 stated that Friday (06/26/2020) was the last time she had a bath and she can smell herself. 06/30/2020 at 04:24 PM Interview with R#3 in 100 Warm Hall although she was listed in the COVID Hall 124A on the map. R#3 stated that she does everything herself. She stated, I even change my own pamper. She stated that she takes a shower every 3 days on her own because staff is busy. 06/30/2020 at 03:01 PM Interview with R#16. She stated that she could not turn herself and now she only gets turned maybe two or three times a day. She stated that the food is always cold. R#16 stated that Friday (06/26/2020) was the last time she had a bath and she can smell herself. 06/30/2020 at 07:45 PM Interview with Administrator. Administrator stated that they gave the very best care to their residents. She does not understand why anyone would complain. Administrator stated that they had a lot of staff out being COVID positive or they just quit, but they are ok. 07/15/2020 at 04:31 PM Interview with R#9. R#9 stated that last week he didn't get changed (adult brief) for 16 hours. He stated that there isn't enough staff to take care of everyone and the resident's suffer. 07/15/2020 at 04:35 PM Interview with R#10. R#10 stated that he hasn't had a shower for 4 days. He stated, They ignore us. 07/17/2020 at 07:26 PM Interview with R#9. Resident stated that

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) he was wet and there was no C.N.A.s to change him. Observation on 06/30/2020 at 03:04 PM Observed R#15 lying in bed on side facing open door and curtain not drawn. Contractures. R#15 was laying on bare plastic mattress with sheet covering only top half of his body. R#15 did not answer when asked if he were ok. He only looked at Surveyor. Record review for R#3 revealed: [AGE] year old female Date of Admission: 02/08/2020 06/25/2020 tested for COVID-19 06/28/2020 Results positive for COVID-19 [DIAGNOSES REDACTED].#9 revealed: [AGE] year old male Date of Admission: 12/09/09 06/25/2020 tested for COVID-19 06/28/2020 Results for COVID-19 negative 07/30/2020 tested for COVID-19 07/30/2020 Unable to obtain results. Surveyor exited facility. [DIAGNOSES REDACTED].#10 revealed: [AGE] year old male Date of Admission: 01/17/18 06/25/2020 tested for COVID-19 06/28/2020 Results for COVID-19 negative [DIAGNOSES REDACTED]. Record Review for R#16 revealed: [AGE] year old female Date of Admission: 02/14/18 Date of Discharge: 07/09/2020 to Home [DIAGNOSES REDACTED]. and [MEDICAL CONDITION] of left femoral vein, Increased white blood cell count, other [MEDICAL CONDITION] embolism without cor pulmonade, Person injured in unspecified motor vehicle accident, traffic 03/21/2020 MDS: BIMS 15 Bed Mobility: Total Dependence, Transfer: Activity Did Not Occur, Dressing: Total Dependence Eating: Supervised, Toilet Use: Total Dependence Personal Hygiene: Total Dependence 02/14/2020 Care Plan: Unable to view 06/22/2020 Skin assessment by RN, Treatment Nurse: Right buttock shear 0.4 x 0.5 x 0.1 Coccyx wound 2.4 x 5.0 x 0.6 Stage 4 Right Distal Forearm scab 1.5 x 1.5 Right Lateral Calf Trauma 5.5 x 0.5 x 0.5
F 0802 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.** Based on interview and record review, the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, for three of three substitute dietary staff reviewed (Administrator, ADON, and Rehabilitation Director). The facility did not employ qualified dietary staff. This failure could place all residents who receive meals from the facility kitchen at risk for not having their nutritional needs met. Findings included: In an interview on 06/30/20 at 7:45 p.m., the Administrator said she had been the one cooking at the facility for about a week, all three meals, because her kitchen staff did not show up. The Administrator said three staff showed up today. The Administrator said she had also had the ADON help her in the kitchen, along with other staff. Observation on 07/03/20 at 12:31 p.m., revealed the Rehabilitation Director delivering a meal tray cart to the 200 COVID Hall. Observation on 07/02/20 at 12:45 p.m., revealed the Rehabilitation Director delivering meal trays to Hall 100 (COVID Hall). In an interview on 07/07/20 at 1:12 p.m., the Rehabilitation Director said he was not an employee of the facility, he worked for another company. The Rehabilitation Director said the facility was short staffed and he helped out wherever he could.
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, and prevent the potential spread of COVID 19. 1) The facility did not consistently assure staff were donning and doffing PPE in separate areas. 2) The facility did not consistently assure staff were not returning to the areas with COVID-19 negative residents after being in the areas with COVID-19 positive residents. 3) The facility did not consistently assure staff were maintaining infection control standards. These failures could place residents at risk of contracting COVID-19, resulting in possible serious illness or death. Findings included: 1) On [DATE] at 1:30 p.m. surveyor entered the facility. The door was open to facility, surveyor did not have to be let in. The Activity Director (AD) was screening at the front door. AD took surveyor's temperature. No screening, education or hand sanitizer was offered. In an interview on [DATE] at 2:50 p.m., the AD said, when someone came in, she sprayed their shoes and took their temperatures. When asked if there was a form that needed filled out, she said that there was, pointed to the form, and shrugged her shoulders. She did not ask the questions on the screening form or attempt to fill out the form. She stated, I spray everyone's shoes and take their temperature when they come in. Observation on [DATE] at 1:40 p.m. revealed the Administrator came out of her office which is located close to the front entrance and left of the reception desk, with her Tyvek suit unzipped, putting on her mask as she was walking out of her office. There are four offices, including the Administrator's office, plus the reception desk located in the small area. This is considered a warm zone (no COVID positive residents in this area). In an interview at the time of observation, the Administrator said her daughter had tested positive for COVID-19 on [DATE], but was asymptomatic. The Administrator said she (Administrator) had tested negative for COVID-19 on [DATE] and was asymptomatic, so she did not have to self-quarantine even though she and her daughter lived in the same house and the daughter worked at the facility in housekeeping. On [DATE] at 04:24 p.m., surveyor observed R#3 residing in a room on the 100 Hall (Warm Hall with COVID-19 negative residents) with the her door and curtain open, not wearing a mask. R#3 was listed in the COVID positive Hall on the facility's resident map, R#3 was confirmed positive for COVID-19 on [DATE]. Observation on the 200 Hall COVID positive Unit on [DATE] at 06:23 p.m., accompanied by the Administrator, revealed LVN A had his face shield up, not covering his face. At the time of observation, the Administrator said LVN A did not have to have his face shield down when in the hall, only in the residents' rooms. Observation on [DATE] at 06:37 p.m. revealed the Lab Technician exiting a resident's room in the Warm zone. The Lab Technician asked surveyor if he (the Lab Technician) could go in the Hot zone (COVID Hall 200). Surveyor stated that she did not work at the facility. The Lab Technician said, Ok, and walked into COVID positive Hall 200 wearing the same gown, mask, and gloves that he was wearing in the COVID negative hall. In an interview on [DATE] at 7:45 p.m., the Administrator said the person screening earlier had been very nervous because State was in the building and that was why she did not do the full screening process. Observation on [DATE] at 12:09 p.m. revealed Corporate Interim DON AA was wearing his white baseball cap, Tyvek coveralls, and an N95 mask. LVN A was wearing Tyvek coveralls with the hood down (no head covering) and a N95 mask. LVN A entered the Warm zone from the COVID positive zone in Hall 200. Corporate Interim DON AA and LVN A were observed exiting the 200 COVID-19 positive Hall into the COVID negative (warm) Hall, without doffing PPE. LVN A was holding the door open with an ungloved hand. When LVN A saw the surveyor, he backed up into the COVID positive Hall and allowed the door to close. Corporate Interim DON AA walked past surveyor and entered the DON's office, closing the door. Within thirty seconds, Corporate Interim DON AA came back out of the DON's office and said, Sorry, I didn't realize you were working in there. (The facility had provided the DON's office as a space for the surveyor to work) Corporate Interim DON AA then walked to the 200 Hall nurse's station (Warm zone) and sat down at the computer. Surveyor asked Corporate Interim DON AA if he had just come out of the Hot zone to the Warm zone. Corporate Interim DON A stated, It's all hot. Surveyor stated, I was informed by the Administrator that this was the warm zone. Corporate Interim DON A replied, Huh, my bad. and continued to sit at the computer in the 200 Hall nurse's station (Warm zone) which leads in to the COVID-19 negative hall where residents reside. On [DATE] at 1:21 p.m., surveyor observed Corporate Interim DON AA in the 200 COVID positive Hall wearing his white baseball cap, with the hood of his Tyvek coveralls down, and an N95 mask. In an interview on [DATE] at 11:36 a.m., the Corporate RN Consultant stated, There was no crossing from the Hot zone to the Warm zone, staff working in the COVID Halls knew to exit through the back. In an interview on [DATE] at 12:35 p.m. on the 200 Hall (Warm), LVN B said she had been working on both the Hot and Warm halls on the same shift. LVN B said they were so short staffed they had to work both halls so the residents were taken care of. LVN B said the Administrator did not care. LVN B said she told the Administrator that some residents showed signs/symptoms of COVID-19, but the Administrator said they were fine. LVN B said yesterday ([DATE]), six of her residents in 300 Hall had fever. LVN B said she called the doctor to get a STAT order for COVID swabs for them. LVN B said, I have seen residents who were positive for COVID-19 before and those six residents were COVID positive. LVN B said the Administrator's daughter had been working yesterday screening in staff. LVN B said the Administrator's daughter, Housekeeper D, had tested positive for COVID-19 on [DATE] and lived with the Administrator. LVN B said the Administrator had not been out of work or self-quarantined at all. In an interview on [DATE] at 12:50 p.m., Medical Records Staff said the Business Office Manager had tested positive around [DATE], and Housekeeper D, the Administrator's daughter, had tested positive for COVID-19 [DATE]. Medical Records Staff said they both worked up until yesterday when the Administrator sent them home. Medical Records Staff said people came in and out of the COVID Hall without donning and doffing. She had observed Corporate Interim DON AA and LVN A crossing between zones without correctly utilizing PPE. Medical Records Staff said that she had observed the Administrator walking throughout the facility (COVID positive halls and negative halls) without PPE on. In an interview on [DATE] at 1:30 p.m., the Med Aide

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) stated that people went in and out of the COVID Halls without donning and doffing their PPE. In an interview on [DATE] at 1:05 p.m., LVN C said R#4 in 300 Hall (warm/negative) had a fever of 100.9 degrees in the morning and was given Tylenol because he did not have any complaints. LVN C said R#4 was on a ventilator. LVN C said R#4's temperature was now 97.8. LVN C said there were no residents in the back 300 Hall (for isolation and consideration as presumptive due a symptom of COVID-19), but Administrator said that the resident could not be moved back there or to the front of 100 Hall. In an interview on [DATE] at 01:15 p.m. Interview with Speech Pathologist. She stated that yesterday ([DATE]), she had observed CNAs from nights who have in the COVID Halls leaving the COVID positive hall, through the warm/negative hall, going to the front to leave after their shift, and taking off their full PPE at the front entrance. She stated, The Corporate Interim DON was standing right there and never said a word. Observation on entering the facility of a cardboard box with a large biohazard bag was sitting at the front entrance full of used Tyvek coveralls in it. During an interview on [DATE] at 5:30 p.m. Administrator stated, As far as I am aware, no one working in the COVID Hall exits out the front. [DATE] at 5:30 p.m. Interview with Administrator and Corporate RN Consultant. Administrator stated, We are waiting on the clearance letter from the Public Health Department clearing staff to come back to work after testing COVID-19 positive. It wasn't official, but Housekeeper D who tested positive for COVID-19 on [DATE], and Business Office Manager who tested positive for COVID-19 on [DATE] came back to work. Housekeeper D came back and worked a day and a half. Epidemiologist said that after 14 days they could come back to work. [DATE] at 10:39 a.m. Administrator stated that the other day, her daughter drove her to the facility at night. She said that she wasn't thinking about her daughter, Housekeeper D, being positive ([DATE]). Administrator stated that she did not self-quarantine after her daughter tested positive because her daughter did not have symptoms and she (Administrator) had tested negative. [DATE] at 11:01 a.m. Interview with LVN B. LVN B stated that when she came in at 10:30 a.m., there was no nurse for 200 Hall. She stated that the LVN who had been there, clocked out at 08:29 a.m She said it was LVN A. She said that he had come in to relieve her around 12:20 a.m. - 12:30 a.m. I came in at 07:30 a.m. on ,[DATE], and LVN A relieved me around 12:,[DATE]:30 a.m There hasn't been a nurse on this hall since 08:29 a.m She said that 200 Hall was a heavy workload hall because the residents needed a lot of help due to the residents with tracheostomies and on ventilators. LVN A is assigned to COVID Halls most the time. LVN B stated that LVN A goes from hot to warm and warm to hot all the time during his shifts without donning and doffing every time. [DATE] at 11:13 a.m. Interview with Medical Records. Medical Records stated that if an employee presented with symptoms other than fever, the ADONs told them they didn't have a fever, they had to work. [DATE] at 11:31 a.m. Received telephone call from the Respiratory Therapist. She observed the Administrator in the 100 COVID positive Hall not wearing PPE. She stated on [DATE], she observed LVN A was assigned 200 and 300 Front Halls (warm) and that he crossed between COVID positive and negative halls during a shift without donning and doffing when crossing. She stated that the Administrator comes in at night a lot and isn't wearing PPE. [DATE] at 12:13 p.m. Observation and interview. Administrator stated that Business Office Manager, tested COVID positive [DATE], considered recovered by Administrator, was told by Administrator to go relieve Medical Records in the back as hall monitor (warm hall). BOM had been working in the front office. Administrator stated, Oh yeah, I guess you could say she was cleared, BOM had not been cleared by Public Health to return to work. [DATE] at 01:22 Telephone interview with County Public Health, Epidemiologist. Epidemiologist stated that he is waiting on a lot of information (labs). He stated that he has not cleared asymptomatic positive facility employees and if he did, they would have to work exclusively with COVID positive residents. He stated, I didn't tell her (Administrator) anyone could go back especially the BOM because she (the BOM) would not be working with COVID positive residents. BOM does not have direct resident care and would only be working with negative staff. [DATE] at 03:16 p.m. Telephone interview with Epidemiologist. Epidemiologist stated that Public Health has to clear facility asymptomatic only COVID positive residents and they need labs to be able to do that. Epidemiologist had not received COVID test results as to who was positive and who was negative. [DATE] at 05:10 p.m. Interview with Administrator. Administrator stated that BOM and Administrator's daughter had been asymptomatic the entire time and it had been 14 days or longer since they received positive results. [DATE] at 08:25 a.m. Telephone interview with LVN G LVN G stated, I was working the night Administrator came in to the facility to give us PPE. She was on 200 Hall (negative)and I saw her (Administrator) at the nurse's station and she wasn't wearing PPE. Lately, she comes in at night. She comes in and helps with CNAs with incontinent care and repositioning. Her daughter tested positive and is working. We're more exposed being around the Administrator when she's not wearing PPE. She didn't quarantine when her daughter who she lives with tested positive ([DATE]) and with the Administrator's daughter being back at work without testing to find out if she's negative after being positive. CNA I, who's positive called the facility. I answered the phone. She wanted to come back to work. She hadn't been tested and said that (Administrator) told her that she didn't have to test, if she were feeling ok, she could come back. The Administrator's daughter, (Housekeeper D), tested positive. She was back on the 5th ([DATE]). She was at the front screening. [DATE] at 03:01 p.m. Administrator in her office and not wearing a mask during the interview with surveyor, stated that the County Public Health Epidemiologist gave verbal approval for staff to come back to work. The Epidemiologist said that the Business Office Manager, LVN J, LVN K, and daughter, Housekeeper D, could come back to work. Epidemiologist also approved 23 residents as recovered. The approval letters are coming soon, but he gave verbal approval on the phone. Administrator stated that the census was 78, 16 residents positive, 23 positive residents recovered and moved to warm halls, 12 positive resident deaths, 2 non COVID resident deaths, and 1 pending result (resident had died but waiting on COVID test results), and 1 positive staff expired at the hospital. We have 1 new positive resident, R#5. His family was going to transfer him, so we had to test him first. He tested positive so he'll be here for at least 14 days. He's asymptomatic. We are not going to test anyone else. We are doing the symptom based - no swabs. Administrator stated that R#6, who was positive for COVID-19 when tested on ,[DATE], was sent to [MEDICAL TREATMENT]. [MEDICAL TREATMENT] sent him to the hospital. Administrator stated that they did not know what hospital he was sent to. Administrator stated that Director of Lab told them that an Inconclusive COVID-19 test result for Respiratory Therapist 1, meant that he was negative for COVID-19. Respiratory Therapist worked in 300 negative Hall. [DATE] at 03:53 p.m. Interview with CNA L. CNA L stated that the reason there was a isolation sign outside of R#7's door was because he had an infection and that's why there is a PPE cart and a sign. He said that they were getting ready to move recovered residents from 200 COVID positive Hall in with negative residents on 200 and 300 negative Halls. [DATE] 04:11 p.m. Observed Laundry Aide entering through the back exit of 300 Hall for start of shift. Staff put on gown and mask, entered anteroom to COVID Hall. No screening being done. No buddy system (observation of another staff for correct donning and doffing) in place for gowning. No hand washing or use of hand sanitizer before, during or after donning prior to entering the COVID Hall . [DATE] at 04;19 p.m. Interview with Administrator, Corporate Interim DON BB, and Corporate RN Consultant (through text messages on Administrator's phone). Corporate Interim DON BB stated that the Doctor's Orders were only for temperature and O2 saturations to be taken along with signs and symptoms (cough, diarrhea, nausea, vomiting, etc.). RN Consultant through text message stated that all vital signs were to be taken every shift that included temperature, pulse, blood pressure, respiration rate, oxygen saturation, and pain along with any signs and symptoms of COVID-19. Administrator reiterated that ALL vital signs were supposed to be taken every shift per Corporate RN Consultant. [DATE] at 04:35 p.m. Interview with R#16. Administrator moved R#11 in with R#9 yesterday. Administrator said he was recovered, but who knows if he is or not. [DATE] at 04:53 p.m. Interview with R#12, in hallway. Resident stated that he came from the back (COVID positive hall) yesterday. He was wearing his mask under his nose. [DATE] at 05:31 p.m., Interview with R#13, who was sitting in the cowboy room (the area between 200 and 300 Hall that leads to the courtyard). R#13 wearing a mask below his nose. [DATE] at 08:52 p.m. Corporate Interim DON BB took Surveyor's temperature before leaving the facility. Administrator stated, I took my temperature this morning and I was ok. I'm not taking it again, and walked out before Surveyor. [DATE] at 03:25 p.m. Telephone interview with Medical Director. Medical Director stated that full set of vitals were to be taken every shift, not just temperature and O2 saturation. Stated that the nurses knew to contact him when the vitals showed a decline in status (example: O2 less than 98%, Temperature more than 99.0 or less than 97.0). Medical Director stated that anything out of the baseline for each resident needed to be reported. [DATE] at 03:30 p.m. Telephone interview with Director of Lab. Director of Lab stated that if an Inconclusive result were received for COVID-19 testing, the lab would immediately re-run the test. She stated that she would never say that an Inconclusive result meant that it was negative. She checked results for Respiratory Therapist V, and said that his results were positive. Director of Lab stated that they most always immediately report the positive COVID-19 results after the first being Inconclusive, but she could not say for 100% that the positive results were reported to the facility, but that she would call the facility as soon as she disconnected with the Surveyor to ensure that the Respiratory Therapist V's positive COVID-19 results were known to the facility. [DATE] at 06:40 p.m., CNA Q in parking lot smoking a cigarette wearing unzipped Tyvek. Opened door.

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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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) LVN E met CNA Q inside door to get bags of clothes from resident's family (room [ROOM NUMBER]). LVN E and CNA Q walked away. Surveyor screened herself in and walked back to the nursing stations. [DATE] at 06:50 p.m. LVN E and CNA Q, moving resident, R#14, out of room in her bed from room. After seeing Surveyor looking through the window into the hall, LVN E told CNA Q to go get a mask for the resident who was lying in her bed in the hallway. LVN E stated that they were moving resident into COVID Hall. [DATE] at 07:04 p.m. Interview with Administrator said the census was 76, 18 positive residents, 9 resident deaths, and 2 positive residents in the hospital. Administrator stated that they had cleared out what used to be 200 COVID Hall and they would be moving negative residents in to that hall. She stated the hall had been disinfected. Surveyor walked down 200 Hall (former COVID positive status Hall) accompanied by Administrator. In most of the rooms, there were still personal belongings of the residents and the beds still had sheets and blankets on them. Administrator stated that the entire hall had been disinfected. [DATE] at 07:58 p.m. Interview with Respiratory Therapist 2. RT 2 stated that there was one RT on shift at night. When asked if she works both COVID positive and COVID negative halls. Administrator came up behind Surveyor. RT 2 looked at Administrator, put her head down and said, No. Respiratory Therapist 2 would not say who was working in the COVID positive hall. Observation on [DATE] at 02:22 p.m. Observed RN, Wound Care Nurse, leaning in the COVID Hall 200 door talking with another staff, LVN A, who was working in the COVID Hall. When interviewed, RN stated that she had to ask him something and doesn't have anyone's phone number to call them. Observations [DATE] at 03:12 p.m. Screening took place when entering facility (Forms filled out, temperature taken, education provided, and hand sanitizer used). An employee, CNA, had arrived before Surveyor. In-servicing took place on PPE/Cross Contamination and Change of Condition/COVID given by Administrator. CNA. signed the in-service paperwork. CNA. donned PPE (Gown, N95, and face shield) with Administrator observing (buddy system). CNA. was assigned to work in the warm hall. 24 staff had signed the PPE/Cross Contamination in-service and 19 staff had signed the Change of Condition/COVID paperwork. A schematic of Donning/Doffing Hot Zone to Warm Zone printout was given to all employees coming on shift as a part of their in-servicing. Mitigation Zone mapping given to staff when entering for their shift. The Administrator stated that she was not a nurse and would not be assessing residents. Plastic barriers were erected blocking the two halls that go around the resident side of the building. The only way to enter the resident side of the building was through the courtyard. Administrator stated that all residents from 100 Hall (negative for COVID) were moved to the 300 Hall for staffing reasons and that they would not be spread out. Adequate nursing for 100 Hall. Regional MDS Advisor will be monitoring resident's charts. She is sending her findings via email. The facility is printing the findings and all nurses get a printout. Documentation and vital signs are being monitored every shift and being reviewed by Regional MDS Advisor. Facility Medical Director, put in place protocol for COVID-19 positive residents. Staff are to complete vital signs including temperature, respirations, blood pressure, pulse and oxygen saturation every shift. Any changes of condition assessed will be reported to facility Medical Director immediately. Staff are to assess at least three times daily so they can quickly identify residents who require transfer to a higher level of care. A cart with full PPE at the entrance to the facility by door. Housekeeping was disinfecting the high touch areas in two of the COVID positive halls and one of the negative halls. Full PPE was being worn by all staff. Signage was up denoting the hot and warm zones and PPE to be worn. Observation on [DATE] at 10:38 a.m. Director of Maintenance and Rehabilitation Director, entered the building, put on gown and mask, and left the entrance area. No screening completed. Observation on [DATE] No housekeeping seen in halls. All hallways cluttered. Observation on [DATE] at 11:11 a.m. No staff seen in 100 COVID Hall at this time. No housekeeping seen. Hallways cluttered with trash cans, med carts, dirty linen, and linen carts. Observation on [DATE] at 06:02 p.m. Paramedic T and Paramedic U entered through 300 Hall exit. No self-screen, no observation/buddy system to don PPE. Entered anteroom to COVID Hall without hand hygiene performed or donning gloves. Record review of the Order issued by (Physician's name), Cameron County Public Health Authority to (facility name), dated [DATE], revealed: Keep the roommate in isolation with droplet precautions and provide dedicated staff who use a buddy system to observe each other donning and doffing. Cohort all patients cared for by staff who worked with any COVID-19 patient between [DATE] and [DATE]. Those staff will be dedicated to this cohort of patients. Do not allow staff from other areas to work in the cohort area. Record review of the facility's Coronavirus Emergency Pandemic Policy Addendum, dated [DATE], revealed: The center's Coronavirus program includes early identification, transmission-based precautions, infection control and transfer of persons with active Coronavirus as needed. Record review of in-service summary and attendance, dated [DATE], revealed: Subject: PPE/Cross Contamination Description of training session: Healthcare workers should wear an N95 respirator and all suggested PPE when caring for residents with COVID-19. When there is widespread COVID-19 infection in the building, staff should wear an N95 respirator and all suggested PPE when caring for residents (including labs, therapy, X0Ray). Per the CDC, 'all suggested PPE' includes N95 respirator, eye protection (face shield/goggles), gloves and gown. Infection Mitigation Zones map which reveals - Requires: Entry and Exit controls, Effective donning and doffing processes. - Staff will be assigned to specific zone and will not be allowed to cross zones for any reason. - Strict Adherence to protocols for med pass, food service, laundry and general facility hyper-sanitization. - Staff restrooms and break rooms must be separate from staff and residents from the warm and cold zones. - Full PPE including N95s must be worn. Gowns must be changed per encounter. Record review of in-service summary and attendance, dated [DATE], revealed: Subject: Change of Condition/COVID Description of training session: Vital signs including temp, respirations, blood pressure, pulse and oxygen saturations will be completed every shift. MD will be notified as well. Any changes condition assessed the MD will be notified immediately. Per CDC guidelines the required assessment of COVID-19 residents that should be followed to identify and manage severe illness is as stated: Monitor ill residents (including documentation of temperature and oxygen saturation) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.