STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675477	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STOCKDALE RESIDENCE AND REHABILITATION CENTER	**300 SALMON STOCKDALE, TX 78160**

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	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 10 of 12 (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) residents observed for infection control, in that: 1. Residents #1, #2, #3, #4, #5, #6, #7, and #8 were not placed under observation status with droplet isolation precautions after a potential exposure to COVID-19 by ST A. 2. The facility did not complete COVID-19 assessments to Resident #1, #2, #3 and #4. 3. Dietary Staff B and C were not wearing face masks while food was prepared in the kitchen. 4. CNAs E and F were wearing surgical face masks and LVN D was wearing a cloth face mask instead of N95 masks. 5. Dirty laundry was not being bagged prior to being placed in the laundry barrels and the laundry barrels were not kept covered. 6. LVN H did not wash or sanitize her hands after removing her gloves during blood glucose monitoring for Residents #2, #9, and #10. 7. LVN H did not sanitize a metal tray, glucose monitor, or medication supplies after use in a resident room. These failures could place residents at risk for a significant change of condition related to COVID-19 and other infections which could result in a decline in health status and/or death. The findings were: 1. Record review of a face sheet for Resident #1, dated 10/07/2020 revealed an admission date of [DATE] with readmission of 02/13/2020 with [DIAGNOSES REDACTED]. Record review of a face sheet for Resident #2, dated 10/07/2020, revealed an admission date of [DATE], with a readmission date of [DATE], with [DIAGNOSES REDACTED]. Record review of a face sheet for Resident #3, dated 10/07/2020, revealed an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Record review of a face sheet for Resident #4, dated 10/07/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of a face sheet for Resident #5, dated 10/07/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of a face sheet for Resident #6, dated 10/07/2020, revealed an admission date of [DATE], with a readmission date of [DATE], with [DIAGNOSES REDACTED]. Record review of a face sheet for Resident #7, dated 10/07/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of a face sheet for Resident #8, dated 10/07/2020, revealed an admission date of [DATE], with a readmission date of [DATE], with [DIAGNOSES REDACTED]. Record review of a document provided by the Administrator, undated, revealed a list of 10 residents (Residents #1-#8 with no prior COVID-19 diagnoses) receiving speech therapy services from ST A with potential exposure to COVID-19. Further review revealed on 10/02/2020 Resident #1 had refused a COVID-19 test. Residents #2-#8 had tested negative for COVID-19 on 10/02/2020. Observation on 10/03/2020 at 4:30 PM revealed Resident #3 outside smoking with a group of 4 unidentified residents. During an interview on 10/03/2020 at 4:30 PM, CNA E confirmed Resident #3 was outside smoking with other residents and further confirmed residents #1-#8 were not on quarantine or on isolation precautions. Observation on 10/03/2020 at 5:00 PM revealed Resident #4 was in the dining room with 4 unidentified residents in the dining room not socially distant. Observation on 10/03/2020 at 5:30 PM revealed Resident #4 was in the dining room with 3 unidentified residents at one dining room table for the evening meal service. Observation on 10/03/2020 at 5:45 PM revealed Residents #1-#8 rooms did not have signs on the doors which indicated any type of isolation was in place. During an interview on 10/30/2020 at 7:15 PM, the DON confirmed Resident's #1-#8 had potential exposure to ST A whom tested positive for COVID-19. The DON confirmed Residents #1-#8 had not been placed under quarantine or placed on isolation precautions after their exposure. The DON stated they had tested Residents #2-#8 for COVID-19 on the date the facility had learned ST A had tested positive, 10/02/2020 and confirmed Resident #1 had refused to be tested . The DON stated since the residents had tested negative she thought they were fine and she did not think they needed to be quarantined for 14 days. The DON stated the staff were still monitoring these residents for signs and symptoms of COVID-19 and had increased the monitoring to every four hours. 2. Record review of Residents #1, #2, #3, and #4's medical records revealed no evidence of monitoring for signs and symptoms of COVID-19 including no COVID assessments. During an interview with LVN I on 10/07/2020 at 10:12 AM LVN I confirmed COVID assessments and vital signs were not documented in the residents #1, #2, #3, and #4's permanent medical records. LVN I stated since 10/02/2020 vitals were performed every four hours but were documented on a sheet of paper which was kept in a binder and were not documented in the residents' medical record. LVN I stated the DON would have more information about the COVID assessments. During an interview on 10/07/2020 at 10:22 AM, the DON confirmed the facility had not provided COVID-19 monitoring and assessments as recommended by the CDC or every 8 hours per facility policy. The DON stated the nursing staff had been instructed to perform a temperature check on each resident once per day until 10/02/2020 and document in the residents' electronic medical record. The DON further stated after 10/02/2020 vitals were recorded every four hours on a sheet of paper where all residents were listed together because it was easier for the nurses. The DON stated these vital sign sheets could not be placed in the permanent medical record because it contained information from more than one resident. The DON further stated that while obtaining vital signs, the nurses performed assessments but were not documenting their findings. The DON further stated staff should only document a change of condition. The DON confirmed the progress notes (nurses notes) did not contain any information to confirm a COVID assessment was completed and the facility did not have an assessment tool in place. 3. Observation on 10/03/2020 at 4:36 PM revealed Dietary Aide B had a cloth mask pulled down around his neck and no mask covering his mouth or nose while preparing food in the kitchen. Further observation revealed Dietary Aide C was sitting on the floor of the kitchen and not wearing a mask. During an interview with Dietary Aide B on 10/03/2020 at 4:38 PM, Dietary Aide B confirmed he was not wearing a face mask while preparing food in the kitchen and Dietary Aide C was also not wearing a mask in the kitchen. During an interview with the Administrator on 10/03/2020 at 7:25 PM, the Administrator confirmed she knew the dietary staff were not wearing N95 mask while in the kitchen. The Administrator further stated the kitchen got very hot while preparing food and a staff member had almost passed out. She had instructed the staff to wear a surgical mask or their own cloth mask while in the kitchen. 4. Observation on 10/03/2020 at 4:20 PM revealed CNA E was wearing a surgical face mask instead of a N95 face mask while interacting with residents. During an interview on 10/03/2020 at 4:20 PM CNA E confirmed she was wearing a surgical face mask instead of a N95 mask. Observation on 10/03/2020 at 4:26 PM revealed LVN D was wearing a cloth mask instead of a N95 face mask. During an interview with LVN D on 10/03/2020 at 4:26 PM, LVN D confirmed she was wearing only a cloth face mask instead of a N95 face mask. LVN D stated the N95 face mask got dirty so she put the cloth face mask on instead. Observation on 10/03/2020 at 4:30 PM revealed CNA F was wearing a surgical face mask instead of a N95 face mask while interacting with residents in their rooms. During an interview with CNA F on 10/03/2020 at 4:30 PM, CNA F confirmed she was wearing a surgical face mask instead of a N95 face mask. CNA F stated she normally wore a cloth face mask because a lot of staff at the facility wore only cloth face masks. Today she forgot her cloth face mask at home so she had stopped at the gas station and purchased a surgical face mask. CNA F stated she was a new hire at the facility and had not had any training on PPE. During an interview with the DON on 10/03/2020 at 7:15 PM, the DON confirmed all staff should wear an N95 face mask while in the facility. The DON stated they know this, and further stated multiple in-services had been given to staff regarding N95 mask usage in the facility. The DON stated she had to constantly monitor the staff for mask compliance.

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) During an interview with the Infection Control Preventionist (ICP) on 10/03/2020 at 6:48 PM, the ICP confirmed all staff in the facility had been issued N95 face masks and should be wearing the N95 face mask when in the facility. The IP stated the facility had issued several N95 masks to each staff member and the facility had plenty of N95 face masks on hand. The ICP further stated that for increased protection staff was instructed to wear a surgical or cloth mask over the N95 to assist in keeping the N95 mask clean. The Infection Preventionist confirmed it was inappropriate for staff to wear a cloth face mask or a surgical face mask in place of the N95 face mask. The ICP stated she had trained staff to wear a face shield or goggles for residents who were under droplet precautions or who were positive for COVID-19. 5. Observation on 10/03/2020 at 4:39 PM revealed four linen barrels full of dirty laundry which was not bagged sitting outside between the laundry building and the main building. Further observation revealed there were no lids covering the linen barrels of dirty laundry. Observation on 10/03/2020 at 4:48 PM revealed CNA G exited a resident's room with dirty clothes in a laundry basket, walked down the hall to the dirty laundry room, and deposited the laundry into a laundry barrel without bagging the dirty clothes. During an interview with CNA G on 10/03/2020 at 4:55 PM, CNA G confirmed he had placed a resident's dirty laundry directly in the laundry barrel without bagging the laundry. CNA G further confirmed he had been trained to bag the dirty laundry in the residents room prior to placing the dirty clothes into the laundry barrel. During an interview with the Infection Control Preventionist on 10/03/2020 at 6:48 PM with the Infection Control Preventionist confirmed staff should only use laundry barrels with lids and the barrel should be covered. 6. Record review of Resident #9's face sheet, dated 10/07/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #10's face sheet, dated 10/07/2020 revealed an admission date of [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. Observation on 10/03/2020 at 4:52 PM revealed LVN H entered Resident #2's room, performed blood glucose monitoring, removed her gloves and then did not wash or sanitize her hands. Further observation revealed LVN H then entered Resident #9's room to perform blood glucose monitoring without performing hand hygiene. After exiting Resident #9's room LVN H removed her gloves but did not wash her hands or use hand sanitizer. Further observation revealed LVN H used her bare hands to push down the trash in the trash located on her medication cart then entered Resident #10's room to perform blood glucose monitoring without performing hand hygiene. During an interview with LVN H on 10/03/2020 at 5:14 PM, LVN H confirmed she did not wash her hands or use hand sanitizer between blood glucose monitoring checks for Residents #2, #9 and #10. LVN H stated she normally had a bottle of hand sanitizer with her, but she did not have it with her at the time and needed to get a new bottle. 7. Observation on 10/03/2020 at 4:52 PM revealed LVN H entered the room to Resident #9 with a metal tray which was placed on the resident's bed. After exiting Resident #9's room the metal tray was placed on top of the med cart without being sanitized. Further observation revealed LVN H then entered the room of Resident #10 with the metal tray that had not been sanitized and placed it on the resident's bed side table. Further observation revealed LVN H exited Resident #10's room without sanitizing the metal tray before again placing in on top of the medication cart. During an interview with LVN H on 10/03/2020 at 5:14 PM, LVN H confirmed she did not sanitize the metal tray between resident use with Resident's #9 and #10. LVN H stated she ran out of sanitizing wipes on her cart and needed to replenish her supply. During an interview with the DON on 10/03/2020 at 6:15 PM, the DON confirmed staff should wash or sanitize their hands between patients and after handling equipment. During an interview with the Infection Control Preventionist on 10/03/2020 at 6:48 PM, the Infection Control Preventionist confirmed staff should wash or sanitize their hands before and after entry into a resident room, when the hands/gloves are soiled and before and after any resident contact. The Infection Control Preventionist further confirmed all communal equipment should be sanitized after use. Record review of the facility's policy titled, Limiting the Transmission of COVID-19, version 14, dated 08/19/2020, revealed, The facility will follow and implement recommendations and guidelines in accordance with the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), and the Texas Department of Health and Human Services (HHSC), to included identification and isolation of any suspected cases. Surveillance and Screening Procedures: Each resident will be monitored for fever and respiratory symptoms every 8 hours and findings will be documented. Social Distancing: Facility will post signs for staff and resident to mind their social distancing throughout the facility and stay at least 6 feet apart from other staff and residents. Suspected case of COVID in the facility-A confirmed or suspected case of COVID-19 will be considered an outbreak. Once a case of COVID-19 is identified in the facility, immediate action will be taken to isolate the resident away from other residents . Record review of the facility's policy titled, Infection Control Plan: Overview, dated 2019, revealed: Preventing Spread of Infection: 3. The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by acceptable professional practice. Linens: Personnel will handle, store, process and transport linens so as to prevent the spread of infections. Record review of the facility's policy titled, Fundamentals of Infection Control Precautions, dated 2019, revealed: Hand Hygiene: Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situation that require hand hygiene: before and after direct resident contact, before and after performing any invasive procedure (e.g. fingerstick blood sampling), before and after entering isolation precaution setting, upon and after coming in contact with a resident's intact skin, after handling soiled equipment or utensils, after removing gloves or aprons .7. Linen and laundry: 1. all soiled linen will be double bagged at the site that it was generated.