STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675214	A. BUILDING _____ B. WING _____	**05/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE RESORT AT TEXAS CITY	**1720 N LOGAN ST TEXAS CITY, TX 77590**

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 0552 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to inform residents in advance of the risks and benefits of proposed care and treatment for 6 of 10 residents and 1 former resident (Residents #1, #2, #3, #4, #5, #7 and CR #13) reviewed for resident rights and COVID-19. The facility failed to inform Residents #1, #2, #3, #4, #5, #7 and CR #13, or their Responsible Parties of newly prescribed medications to treat COVID-19, and did not inform them of risks and benefits of treatment. This failure could affect all residents and placed them at risk of receiving treatments without informed consent and an inability to make an informed decision about care. Findings include: Resident #1 Record review of Resident #1's clinical record revealed he was admitted on [DATE] and had [DIAGNOSES REDACTED]. He was [AGE] years of age. Record review of Resident #1's care plan (undated) revealed he had impaired cognitive function due to [MEDICAL CONDITION] and dementia. Interventions included administer medications as ordered, types of communication, simple and structured activities and monitor/document any changes in cognitive function. Record review of Resident #1's MDS assessment dated [DATE] revealed he had a BIMS score of 5, indicating he had severe cognitive impairment. He had signs of inattention and disorganized thinking that fluctuated (comes and goes, changes in severity). Observation and attempted interview on 4/28/20 at 11:35am revealed Resident #1 was sitting in the dining room chatting with facility staff. He was in the secure unit of the facility. He was not interviewable. Record review of a list of residents with their COVID-19 test results (undated) revealed a hand-written note that indicated Resident #1 was tested on [DATE] and his result was positive. Record review of Resident #1's physician's orders [REDACTED]. of 4/8/20; Zinc Sulfate capsule 220mg, give 1 capsule by mouth one time a day for 5 days for zinc deficiency with a start date of 4/8/20. Record review of Resident #1's TAR dated April 2020 revealed he was administered the following medications: [REDACTED]. Record review of Resident #1's facesheet dated [DATE] revealed his responsible party and health care power of attorney was his Family Member. Record review of Resident #1's Nursing Notes dated [DATE]/20-[DATE]0/20 revealed there was no documentation indicating Resident #1's responsible party was notified nor that he consented to the COVID-19 medication regimen. In a telephone interview on 4/9/20 at 11:30am, Resident #1's family member said Resident #1 was in the memory care unit because he had dementia. He said Resident #1 could not make his own decisions, which was why he was POA. He said he called the facility on Sunday 4/5/20, after reading news reports about COVID-19 in the facility. The facility was surprised that he was not told, and he then found out Resident #1 had COVID-19. He said they never got back to him, so 4 days later he called again. He said they had a special doctor with the approval of the governor to treat with a certain medication. He said called yesterday to see how his family member was doing. He said he spoke to the Social Worker. He said the Social Worker said they were checking EKG levels and O2 sats. He said the Social Worker told him that Resident #11 was not involved with the new drug. When asked if he would like to know if Resident #1 received a new medication, he said yes he would like to be informed. Resident #2 Record review of Resident #2's clinical record revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was [AGE] years of age. Record review of Resident #2's care plan (undated) revealed he had impaired cognitive function or impaired thought processes due to dementia and [MEDICAL CONDITION]. Interventions included, Administer medications as ordered, discuss concerns about confusion, disease process, (nursing home) placement .keep the resident's routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion . Record review of Resident #2's MDS assessment dated [DATE] revealed he was rarely/never understood and had short-term and long-term memory problems. He had severely impaired cognitive skills for daily decision making. In an observation on [DATE]9/20 at 4:25pm, Resident #2 was in bed, asleep. His room was located in the isolation hallway. Record review of Resident #2's Clinical Report of laboratory results dated [DATE] revealed he was positive for COVID-19. Record review of Resident #2's physician orders [REDACTED]. for 4 days for COVID-19 with a start date of 4/7/20; Zinc 220mg capsule, give 1 capsule by mouth one time a day for COVID-19 for 5 days with a start date of 4/8/20. Record review of Resident #2's TAR dated April 2020 revealed he was administered the following medications: [REDACTED]. Record review of Resident #2's facesheet dated [DATE]/20 revealed his responsible party was his Family Member. Record review of Resident #2's Nursing Notes dated [DATE]/20-[DATE]0/20 revealed there was no documentation indicating Resident #2's responsible party was notified nor that she consented to the COVID-19 medication regimen. In a telephone interview on 4/9/20 at 12:18pm with Resident #2's family member, she said she had not seen her family member in 3-4 weeks. She said she called and spoke to the social worker. She said they told her he had coronavirus. Said she thought that was on Sunday, 4/5/20. When asked when was the last time someone from the facility called, she said yesterday. They gave her an update- they said he was doing good and He was eating well and he was acting like himself. She said they did not give any information about his treatment or medications. Resident #3 Record review of Resident #3's clinical record revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years of age. Record review of Resident #3's care plan (undated) revealed she had impaired cognitive function or impaired thought processes related to impaired decision making. Interventions included administer medications as ordered, ask yes/no questions in order to determine resident's needs and communicate with the resident/family/caregivers regarding residents capabilities and needs. Record review of Resident #3's MDS assessment dated [DATE] revealed she was rarely/never understood. She had short-term and long-term memory problems and had moderately impaired cognitive skills for daily decision making. He had signs of inattention and disorganized thinking that fluctuated (comes and goes, changes in severity). In an observation and attempted interview on [DATE]9/20 at 3:20am, Resident #3 was sitting in a wheelchair in the doorway of her room. She was on the isolation unit. She was not interviewable. Record review of Resident #3's COVID-19 testing dated 4/3/20 revealed she tested positive for COVID-19. Record review of Resident #3's physician orders [REDACTED]. date of [DATE]. Record review of Resident #3's TAR dated April 2020 revealed she was administered the following medications: [REDACTED]. Record review of Resident #3's facesheet dated [DATE] revealed her Primary Contact was her Family Member. Record review of Resident #3's Nursing Notes dated [DATE]/20-[DATE]0/20 revealed there was no documentation indicating Resident #3's responsible party was notified nor that she consented to the COVID-19 medication regimen. In a telephone interview on [DATE]3/20 at 9:41am with Resident #3's family member, she said she was notified when Resident #3 had a chest x-ray that confirmed she had pneumonia. She said 2 days later, the facility's COVID-19 cases was reported on the news. She said the next day, she called and had a hard time reaching someone. She said she was always placed on hold and only spoke to the receptionist. She said they told her Resident #3 did test positive for COVID-19. She said she was never notified of the type of treatment she was on. She said she heard in the news the residents were getting the experimental medication. She said she would have liked to be notified before the medication was given. She said she still does not know how they were treating Resident #3. Resident #4 Record review of Resident #4's clinical record revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was [AGE] years of age. Record review of Resident #4's care plan (undated) revealed he had impaired cognitive

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) function or impaired thought processes due to dementia. Interventions included administer medications as ordered, ask yes/no questions in order to determine resident's needs and communicate with the resident/family/caregivers regarding residents capabilities and needs. Record review of Resident #4's MDS assessment dated [DATE] revealed he had a BIMS score of 1, indicating he had severe cognitive impairment. He had signs of inattention that fluctuated (comes and goes, changes in severity). Record review of Resident #4's COVID-19 testing dated 4/3/20 revealed he tested positive for COVID-19. Record review of Resident #4's physician orders [REDACTED]./20. Record review of Resident #4's MAR indicated [REDACTED]. Record review of Resident #4's TAR dated April 2020 revealed he was administered the following medications: [REDACTED]. Record review of Resident #4's facesheet dated [DATE] revealed his responsible party was his Family Member. Record review of Resident #4's Nursing Notes dated [DATE]/20-[DATE]0/20 revealed there was no documentation indicating Resident #3's responsible party was notified nor that she consented to the COVID-19 medication regimen. In a telephone interview on 4/9/20 at 2:26pm, Resident #4's family member said on 4/2/20 or 4/3/20, she was notified that Resident #4 had COVID-19. She said the day before yesterday on 4/7/20, she was notified by a staff member that he would be treated with the [MEDICATION NAME] medication. She told them that she had to think about it, since he was prone to [MEDICAL CONDITION] and that was a side effect. She said she called them back yesterday and told them it was okay. She said she wanted to do her own research first. She said she was aware they were checking EKGs and O2 levels. She said she was not sure when they started the medication. Resident #5 Record review of Resident #5's clinical record revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years of age. Record review of Resident #5's care plan (undated) revealed she had impaired cognitive function and impaired thought processes related to dementia. Interventions included use communication techniques, engage in simple, structured activities, keep routine consistent and try to provide consistent caregivers as much as possible. Record review of Resident #5's MDS assessment dated [DATE] revealed she was rarely/never understood. She had short-term and long-term memory problems. She had modified independence for daily decision making. In an observation and attempted interview on [DATE]9/20 at 3:20pm, Resident #5 was in her room, watching TV. She spoke of her family and life. When asked questions, she did not respond appropriately. Her room was located on the isolation hall. Record review of Resident #5's COVID-19 Testing dated 4/3/20 revealed she tested positive for COVID-19. Record review of Resident #5's physician orders [REDACTED]. 4/4/20; Zinc Sulfate 220mg, give one capsule by mouth once daily for coronavirus with a start date of 4/5/20. Record review of Resident #5's TAR dated April 2020 revealed she was administered the following medications: [REDACTED]. Record review of Resident #5's Nursing Notes dated [DATE]/20-[DATE]0/20 revealed there was no documentation indicating Resident #3's responsible party was notified nor that she consented to the COVID-19 medication regimen. Resident #7 Record review of Resident #7's clinical record revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years of age. Record review of Resident #7's care plan (undated) revealed she had impaired cognitive function and impaired thought processes related to dementia. Interventions included use communication techniques, engage in simple, structured activities, keep routine consistent and try to provide consistent caregivers as much as possible. Record review of Resident #7's MDS assessment dated [DATE] revealed she had a BIMS score of 5, indicating she had severe cognitive impairment. She had signs of inattention and disorganized thinking that fluctuated (comes and goes, changes in severity). In an observation on [DATE]9/20 at 3:47pm, Resident #7 was in bed, asleep. She had [MED]gen on. Her room was located in the isolation hall. Record review of Resident #7's COVID-19 Testing dated 4/3/20 revealed she tested positive for COVID-19. Record review of Resident #7's physician orders [REDACTED]./6/20. Record review of Resident #7's TAR dated April 2020 revealed she was administered the following medications: [REDACTED]. Record review of Resident #7's Nursing Notes dated [DATE]/20-[DATE]0/20 revealed there was no documentation indicating Resident #3's responsible party was notified nor that she consented to the COVID-19 medication regimen. CR#13 Record review of CR#13's face sheet revealed he was a [AGE] year old male that was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. CR#13 was discharged from the facility on 04/06/20. Record review of CR#13's MDS dated [DATE] revealed CR#13 had a BIMS of 7, indicating moderate cognitive impairment. Record review of CR#13's laboratory results dated [DATE] for COVID -19 Testing revealed COVID-19 was not detected. Record review of CR#13's Physician order [REDACTED].[MEDICATION NAME] Tablet 200 MG Give 1 tablet by mouth two times a day for COVID 19 for 1 day .Start Date 04/06/20 End Date 04/07/20 Record review of CR#13's Physician order [REDACTED].[MEDICATION NAME] Tablet 200 MG Give 1 tablet by mouth two times a day for COVID 19 for 4 day .Start Date 04/07/20 End Date 0[DATE]1/20 Record review of CR#13's Treatment Administration Record dated 04/2020 revealed CR#13 was administered [MEDICATION NAME] Tablet 200 MG on 04/06/20 in the evening. In an interview on 0[DATE]7/2020 at 4:36 PM Family Member stated they were not made aware of any COVID-19 treatment or medication given to CR#13. The Family Member said she did not give consent for medications. Record review of CR#13's hospital records dated 04/07/20 revealed Primary Impression: [DIAGNOSES REDACTED] Secondary Impressions: Diarrhea, Elevated troponin, [MEDICAL CONDITION] of [MEDICAL TREATMENT], Pleural effusion, [MEDICAL CONDITION] Volume overload . In a telephone interview on 4/7/20 at 3:39pm, the Medical Director, when asked about drug regimen for COVID-19 positive residents, he said he was using tapered [MEDICATION NAME] and zinc. When asked why he chose this combination, he said since nursing homes have a fragile population, they were trying to keep people out of the hospital and prevent them from declining. When asked about the risks of taking the medications, he said it could cause QT prolongation- meaning heart rhythm changes or arrhythmia. When asked if they notified families or responsible parties of treatment, he said, No, we didn't, because it is an off-label use. He said he did not think they needed consent to start drug regimen. He said the residents they were giving it to were alert and oriented. In a telephone interview on 4/9/20 at 4:00pm, the ADON said the residents looked great and she thought the treatment might be working. She said the residents who had COVID-19 had minimal symptoms. She said the residents' families were notified of the COVID [DIAGNOSES REDACTED]. She said she had been making calls to families about the treatment and medications. She said she had a written list of families she has called and would provide. She said if they had questions about the medications, she would explain the risks of taking it. Record review of a document provided by the ADON revealed a list of resident's responsible parties. There were no dates/times that the family members were notified. The list included Resident #3 and Resident #4's responsible parties. In a telephone interview on [DATE]1/20 at 1:15pm, the Administrator said she was not sure about the medications and notifications because the Medical Director was in charge. She was not clinical personnel. Record review of a Houston Chronicle Article dated 4/7/20 at the website https://www.houstonchronicle.com/news/houston-texas/article/texas-city-doctor-drug-covid-19-nursing-home- 720.php read in part, .(Medical Director) holds a bottle of [MEDICATION NAME] while posing outside (nursing home), where he is the medical director, Tuesday, April 7, 2020, in Texas City, Texas. (The Medical Director) is treating nearly 30 residents of the nursing home with the anti-[DIAGNOSES REDACTED] drug [MEDICATION NAME], which is unproven against COVID-19 even as President Donald Trump heavily promotes it as a possible treatment. The doctor who prescribed an unproven medication to more than two dozen COVID-19 patients at the (nursing home), the site of one of the largest outbreaks in the Houston area, said the decision was between him and his patients and he did not notify families before the drugs were administered . Record review of the facility's policy for Resident Rights dated October 2009 read in part, Employees shall treat all residents with kindness, respect and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: .choose a physician and treatment and participate in decisions and care planning .
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment plan of care for 6 of 10 residents (Residents #1, #2, #3, #4, #5 and #7) reviewed for comprehensive care planning and COVID-19. - The facility failed to ensure Residents #1, #2, #3, #4, #5 and #7 had a person-centered care plan the included medical and nursing interventions and goals when they tested positive for COVID-19. This failure could affect all residents in the facility and placed them at risk of not having their care needs met, which could cause a decline in physical and psychosocial health. Findings include: Resident #1 Record review of Resident #1's clinical record revealed his [DIAGNOSES REDACTED]. And he was [AGE] years of age. Record review of Resident #1's MDS assessment dated [DATE] revealed he had a BIMS score of 5, indicating he had severe cognitive impairment. He had signs of inattention and disorganized thinking that

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) fluctuated (comes and goes, changes in severity). Record review of Resident #1's Care Plan dated 3/12/20 revealed he was at risk for alteration in psychosocial well-being related to visitor restrictions and concerns related to COVID-19. Interventions included, encourage alternate forms of communication with visitors, assist with alternate forms of communication with visitors . monitor for psychosocial changes .observe and report any changes in emotional status caused by situational stressor, educate resident/family about public health emergency and changes as indicated . Record review of a list of residents showing their COVID-19 test results (undated) revealed a hand-written note that shows Resident #1 was tested on [DATE] and his result was positive. Further record review of Resident #1's care plan (undated) revealed there was no care plan for nursing and medical interventions, objectives and timeframes for treatment of [REDACTED].#1 was sitting in the dining room chatting with facility staff. He was in the secure unit of the facility. He was not interviewable. Resident #2 Record review of Resident #2's clinical record revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was [AGE] years of age. Record review of Resident #2's Care Plan dated 3/12/20 revealed he was at risk for alteration in psychosocial well-being related to visitor restrictions and concerns related to COVID-19. Interventions included, encourage alternate forms of communication with visitors, assist with alternate forms of communication with visitors . monitor for psychosocial changes .observe and report any changes in emotional status caused by situational stressor, educate resident/family about public health emergency and changes as indicated . Record review of Resident #2's Clinical Report of laboratory results dated [DATE] revealed he was positive for COVID-19. Further record review of Resident #2's care plan (undated) revealed there was no care plan for nursing and medical interventions, objectives and timeframes for treatment of [REDACTED].#2 was in bed, asleep. His room was located in the isolation hallway. Resident #3 Record review of Resident #3's clinical record revealed she was admitted on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years of age. Record review of Resident #3's MDS assessment dated [DATE] revealed she was rarely/never understood. She had short-term and long-term memory problems and had moderately impaired cognitive skills for daily decision making. He had signs of inattention and disorganized thinking that fluctuated (comes and goes, changes in severity). Record review of Resident #3's Care Plan dated 3/12/20 revealed he was at risk for alteration in psychosocial well-being related to visitor restrictions and concerns related to COVID-19. Interventions included, encourage alternate forms of communication with visitors, assist with alternate forms of communication with visitors . monitor for psychosocial changes .observe and report any changes in emotional status caused by situational stressor, educate resident/family about public health emergency and changes as indicated . Record review of Resident #3's COVID-19 testing dated 4/3/20 revealed she tested positive for COVID-19. Further record review of Resident #3's care plan (undated) revealed there was no care plan for nursing and medical interventions, objectives and timeframes for treatment of [REDACTED].#3 was sitting in a wheelchair in the doorway of her room. She was on the isolation unit. She was not interviewable. Resident #4 Record review of Resident #4's clinical record revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was [AGE] years of age. Record review of Resident #4's MDS assessment dated [DATE] revealed he had a BIMS score of 1, indicating he had severe cognitive impairment. He had signs of inattention that fluctuated (comes and goes, changes in severity). Record review of Resident #4's Care Plan dated 3/12/20 revealed he was at risk for alteration in psychosocial well-being related to visitor restrictions and concerns related to COVID-19. Interventions included, encourage alternate forms of communication with visitors, assist with alternate forms of communication with visitors . monitor for psychosocial changes .observe and report any changes in emotional status caused by situational stressor, educate resident/family about public health emergency and changes as indicated . Record review of Resident #4's COVID-19 testing dated 4/3/20 revealed he tested positive for COVID-19. Further record review of Resident #4's care plan (undated) revealed there was no care plan for nursing and medical interventions, objectives and timeframes for treatment of [REDACTED].#5 Record review of Resident #5's clinical record revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years of age. Record review of Resident #5's MDS assessment dated [DATE] revealed she was rarely/never understood. She had short-term and long-term memory problems. She had modified independence for daily decision making. Record review of Resident #5's Care Plan dated 3/12/20 revealed he was at risk for alteration in psychosocial well-being related to visitor restrictions and concerns related to COVID-19. Interventions included, encourage alternate forms of communication with visitors, assist with alternate forms of communication with visitors . monitor for psychosocial changes .observe and report any changes in emotional status caused by situational stressor, educate resident/family about public health emergency and changes as indicated . Record review of Resident #5's COVID-19 Testing dated 4/3/20 revealed she tested positive for COVID-19. Further record review of Resident #5's care plan (undated) revealed there was no care plan for nursing and medical interventions, objectives and timeframes for treatment of [REDACTED].#5 was in her room, watching TV. She spoke of her family and life. When asked questions, she did not respond appropriately. Her room was located on the isolation hall. Resident #7 Record review of Resident #7's clinical record revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was [AGE] years of age. Record review of Resident #7's MDS assessment dated [DATE] revealed she had a BIMS score of 5, indicating she had severe cognitive impairment. She had signs of inattention and disorganized thinking that fluctuated (comes and goes, changes in severity). Record review of Resident #7's Care Plan dated 3/12/20 revealed he was at risk for alteration in psychosocial well-being related to visitor restrictions and concerns related to COVID-19. Interventions included, encourage alternate forms of communication with visitors, assist with alternate forms of communication with visitors . monitor for psychosocial changes .observe and report any changes in emotional status caused by situational stressor, educate resident/family about public health emergency and changes as indicated . Record review of Resident #7's COVID-19 Testing dated 4/3/20 revealed she tested positive for COVID-19. Further record review of Resident #7's care plan (undated) revealed there was no care plan for nursing and medical interventions, objectives and timeframes for treatment of [REDACTED].#7 was in bed, asleep. She had oxygen on. Her room was located in the isolation hall. In an interview on 5/13/20 at 1:00pm, the MDS Nurse said the previous MDS nurse created care plans for all residents about COVID-19. She said they thought it would cover the COVID-19 care plans. She said they got 10 or so residents results in a day, and it was difficult to keep up with. She said residents who were COVID-19 positive should have had a care plan addressing their needs. She said could have done one that was more individualized with interventions. She said the Medical Director and his team were doing what they were doing and may not have communicated with nursing home staff. In an interview on 5/13/20 at 3:45pm, the Administrator said with everything going on, they did not have time to keep up with paperwork, including care plans. Record review of the facility's policy for Care Plans-Comprehensive dated October 2010 read in part, An individualized comprehensive care plan that includes measureable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident .