STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LUBBOCK HOSPITALITY NURSING AND REHABILITATION CEN	4710 SLIDE RD LUBBOCK, TX 79414

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 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 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; affecting 19 of 21 residents (Residents #1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 and #19), in that: a) There was co-mingling of quarantined and non-quarantined residents in a common area. Quarantined Residents and non-quarantined residents were eating together in the same dining room. Residents were observed coughing and not wearing mask in this common/communal area (Residents #3, 4, 5, 9, 10, 11, 12, 13, 16, 17, 18 and 19). b) PPE (personal protective equipment - face masks, face shields, gowns) was not worn in a manner to prevent the transmission of infections. (CNA #1, #2, #6 and #7, LVN #1, Screener). PPE was not stored in a manner to prevent contamination of the PPE, resident use equipment and/or its surroundings. (mask, face shield, gowns). c) Communication of resident quarantine status was not adequate. Dietary staff were unaware of all residents currently on quarantine and quarantined residents were not consistently served meals on disposable dishware (Residents #11, 14, 16 and 17). These failures resulted in the identification of an IJ on 8/11/20 at 3:23 PM. While the IJ was removed, the facility remained out of compliance at a severity level of no actual harm with a potential for more than minimal harm that is not Immediate Jeopardy and a scope of pattern. These problems could result in the spread of COVID-19 related infections, including, but not limited to related pneumonia, vomiting, diarrhea, respiratory distress and death. The findings include: >Co-mingling quarantined with non-quarantined residents in common/communal areas: Background: Record review of the facility's Residents and Employees with Possible Exposures list revealed that the following residents were Exposed prior to 7/9/20 by the Therapy Director: #14, #11 . It further documented residents possibly exposed on 7/20/20 by CNA #3 were: Residents #4, #5, #10, #9, #6 and #7. On 7/29/20 at 9:38 AM an interview was conducted with the DON regarding residents who had tested positive for COVID-19. She stated that Residents #11 and #14 tested positive on 7/15/20 and were transferred to a facility with a COVID unit for care. She added that Resident #11 had returned (7/28/20). Record review of the discharging facility's nurse notes for Resident #11 revealed the following, .7/27/20 1:06 AM. Primary Diagnosis .COVID-19 .Infection Monitoring and Evaluation: Active Infection .COVID-19, Short of Breath, Resident on Isolation . On 8/12/20 at 4:05 PM the DON stated that it looks like they (discharging facility) did not test (Resident #11 for COVID-19). Record review of the nurse notes revealed that on 8/10/20 Resident #14 was readmitted to the facility (room [ROOM NUMBER]) from another nursing facility. Record review of the face sheet revealed that Resident #17 (8/11/20) was admitted to the facility from the community. Interview with the DON on 8/12/20 at 4:05 PM revealed Resident #16 (8/08/20) was admitted from home. Co-mingling Issues: Record review of the email from the DON dated 7/30/20 at 10:18 AM it stated that the tables in the small dining room were square and 42.5 inches. It further stated they were 5 feet between each table. On 7/29/20 at 8:42 AM an interview was conducted with LVN #1 regarding the residents and CNAs present in the small dining room. She stated that the residents were on isolation (#3, 4, 9, 11 and 12). She identified CNA #1 as the CNA who was assisting Residents #11 and #4 with eating. Both residents had Styrofoam dinnerware and both were seated at the same square table at opposite ends. Resident #11 was seated in a wheelchair and Resident #4 was seated in a reclined wheelchair. CNA #2 was identified as the CNA that was assisting Resident #3 who was also eating from Styrofoam dishware. The resident was in a wheelchair and obese. It was further noted in the dining room that there were two residents at the same table one being Resident #9 who had Styrofoam dishware and was obese and in a wheelchair. She was seated at the same square dining room table opposite Resident #12 who was eating from regular dishware. Resident #12 was not quarantined. On 7/29/20 at 9:03 AM it was noted that there were residents in the small dining room without masks on and the breakfast meal was over. There were six residents present: Residents #9, #12, #4, #11, #3 and #13. Resident #9 was noted at this time to be coughing and had no mask on. Resident #9 was seated at the table with Resident #12. Resident #4 was seated at the table with Resident #11. This table was next to resident #9 and #12's table. On 7/29/20 at 9:12 AM Resident #4 was observed in the small dining room in his reclined wheelchair and making a congested sound. On 7/29/20 at 9:22 AM in the small dining room it was noted that Resident #4 coughed and was not wearing a mask. Four residents were in the dining room at this time. Resident #9 was also in the dining room with no mask on. She coughed in her hand. There were two residents nearby sitting at a table, Residents #4 and #11, who were present but were not wearing masks. There was no staff intervention to move these residents, offer them a mask or ensure Resident #9 washed her hands after she coughed in them. On 7/29/20 at 9:23 AM Resident #11 was observed in the small dining room coughing and she had no mask on at the time. She was seated at the table with Resident #4 who also did not have a mask on. Record review of the current physician orders for Resident #4 revealed that the resident was admitted to hospice on 1/07/20. Record review of the progress notes for Resident #11 dated 7/28/20 3:35 PM and created by the DON revealed the following documentation, Resident arrived back from . at approximately 2:30 PM after being sent there for COVID positive care. Residents eyes are matted together, her face is not clean, and she is obviously congested . On 7/29/20 at 9:47 AM Resident #11(COVID +) was observed in the small dining room at the same table with Resident #4. Resident #9 was also in the small dining room at the table next to them. Resident #11 was rubbing her nose and sniffling. None had on masks. On 7/29/28 12:17 PM Resident #9 was in the small dining room in her wheelchair. The resident was coughing and was served her lunch on Styrofoam dishware. The resident was making no consistent attempt to cover her mouth as she coughed. She coughed in her hand. It was also noted that at the next table over was Resident #11 who now had on a surgical mask and was offering no resistance to the mask. On 7/29/20 at 3:53 PM an interview was conducted with the DON. The DON was asked the reason why quarantined and non-quarantined residents were eating together in the small dining room. She stated, We have too many (quarantined residents) to feed them in their rooms. When ask about Resident #11's coughing she stated, I assessed her when she came back, and she had no cough then. -On 8/11/20 at 5:35 PM an interview was conducted with the DON. When asked about Resident #11 she stated, She is still on isolation (quarantined for COVID-19). Record review of the discharging facility's nurse notes for Resident #11 revealed the following, .7/27/20 1:06 AM. Primary Diagnosis .COVID-19 .Infection Monitoring and Evaluation: Active Infection .COVID-19, Short of Breath, Resident on Isolation . Record review of the email from the DON dated 7/30/20 at 10:18 AM it stated that the tables in the small dining room were square and 42.5 inches. It further stated they were 5 feet between each table. On 8/11/20 at 3:58 PM Resident #11 was observed in the small dining room with no mask on and seated in her wheelchair. Resident #10, who was not currently on quarantine, was also seated in the small dining room with no mask. On 8/11/20 at 5:25 PM it was noted that there were three residents in the large dining room seated at separate tables (42.5 inches square). Resident #11 was seated at a table and was wearing a mask. Resident #13 and #18, who were not currently on quarantine, were present and were not wearing masks. On 8/12/20 at 8:55 AM, in the small dining room, Resident #11 was feeding herself. Residents #18, #13, #5, #19 and Resident #9 were present and were not currently quarantined . On 8/12/20 at 12:59 PM it was also noted in the small dining room that all the residents, six, required assistance with eating. These residents were not quarantined except for Resident #11. On 8/12/20 at 4:05 PM the DON was interview regarding how staff are trying to ensure that quarantined and non-quarantine

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) residents do not co-mingle. She stated, During in-services we tell them to try to keep residents in their room. We offer a mask. They are urged to stay in their rooms. Dementia Unit: -On 8/11/20 at 3:53 PM observations were made in the dementia unit. There were 13 residents wandering in the lobby/dining area of the unit and had no masks on. On 8/12/20 at 8:45 AM in the dementia unit it was noted that rooms 47 (Resident #17) and 51 (Resident #16) had PPE storage cabinets outside the rooms. All residents were wandering in the dining room. CNA #8 stated at this time, We got him (Resident #17) yesterday (8/11/20) and her (Resident #16) Saturday (8/08/20). We have no (biohazard) boxes in their rooms. They (dementia residents) drag them around. They are out there (biohazard storage room located outside of the unit). She stated referring to the residents, They won't stay in their rooms. On 8/12/20 at 9:47 AM the DON was asked her plan for quarantining the two residents that were new admits on the dementia unit, Resident #16 and Resident #17. She stated, We can't really quarantine them. They had them COVID tested . They were APS cases. We knew they would not comply. We monitor all signs and symptoms of COVID. They had to be negative before they got here. Record review of the current clinical record for Resident #16 and Resident #17 revealed that there was a negative COVID-19 lab test for Resident #17 (dated 8/05/20), but there was no documentation of COVID-19 testing for Resident #16. On 8/12/20 at 4:05 PM the DON was interviewed. Regarding Resident #16 she stated, Our Marketer said they (APS) didn't do that (test for COVID status) since they came from home. She further stated that the resident was taken from her home where she often wandered the community. The DON was then asked if she had made any attempts to get the resident tested since her arrival on Saturday (8/08/20). She stated, No, no attempts at testing. On 8/11/20 at 5:40 PM an interview was conducted with the DON. When asked what type of plan was in place for COVID-19? She stated, We don't except COVID-19 positive residents. New admits are not excepted unless they have a negative test. We quarantine them for 10 to 14 days. [MEDICAL TREATMENT] residents are tested , or we don't take them. On 8/12/20 at 4:15 PM the Assistant Administrator was asked about documentation of the facility's policy of not admitting any residents that were COVID positive. She stated, It's our internal policy, it's not written. >PPE (personal protective equipment) not wore properly: -On 7/29/20 at 8:40 AM the surveyor entered the facility and the Entrance Screener had on a surgical facemask but his nose was exposed throughout the screening. - On 7/29/20 at 8:42 AM it was noted that two staff members were assisting residents with eating in the small dining room. CNA #1 had her surgical mask pulled completely off her nose and mouth and had no face shield on. She was assisting Residents #11 and #4 with eating. The other staff member, CNA #2, had her nose exposed from her surgical mask and had no face shield on. She was assisting Resident #3 with eating. At this time, an interview was conducted with LVN #1 regarding the residents and CNAs present in the small dining room. She stated that the residents were on isolation. On 7/29/20 at 1:00 PM an interview was conducted with CNA #1 related to her lack of a facemask and face shield when feeding residents breakfast. She stated We're supposed to wear them (mask and face shields) with patient care. I don't know what happened this morning. I know mine (face shield) was off because I saw it on the back of my chair. -On 7/29/20 at 9:07 AM LVN #1 was observed donning a disposable gown and did not secure it at the waist. She entered room [ROOM NUMBER] and had her N95 masks on top of her surgical mask. When she left the room, she pulled the N 95 mask down and placed it under her chin along her neck. Record review of the 7/20/20 Progress Notes for the residents residing in room [ROOM NUMBER] (Residents #1 and #2) revealed that they had been in contact with a COVID positive employee. On 7/29/20 at 9:23 AM LVN #1 was observed wearing a surgical facemask and putting her N95 mask on top. She then placed it under her chin. Again on 7/29/20 at 11:30 AM in room [ROOM NUMBER] LVN #1 was observed donning an N95 mask over her surgical facemask and then later pushing the N95 mask under her chin. Record review of the facility In Service Tracking, Post In-Service Attendance date of 5/15/20 revealed that an in-service labeled COVID precautions and PPE were attended by staff including LVN #1. -On 8/11/20 at 3:53 PM observations were made in the dementia unit. There were 13 residents in the lobby/dining area of the unit and had no masks on. CNA #6 had her nose out of her surgical mask but was wearing a face shield. On 8/11/20 at 5:20 PM an observation was made of the dementia unit. It was also noted that CNA #6 still had her nose out of her surgical mask but was wearing a face shield. They were serving residents their evening meal. On 8/12/20 at 2:47 PM an observation was made of the dementia unit. CNA #6 had her nose exposed from her surgical mask and she was wearing a face shield that was tilted outward from her face. -On 8/12/20 at 12:05 PM CNA #7 was seated at Nurse Station 1 and her mask was off of her nose. >PPE storage: Background: On 7/29/20 at 9:03 AM it was noted that room [ROOM NUMBER] had red and yellow biohazardous boxes present in the room. The residents who resided in this room were Residents #1 and #2. LVN #1 stated at this time that these residents were in contact with a CNA that was COVID positive. She stated regarding room [ROOM NUMBER] that the resident residing there was Resident #3. She stated that she was a new admit and she would be in quarantined for 14 days since she had come from the hospital. There were quarantine PPE storage cabinets in the corridors outside of these resident rooms On 7/29/20 at 9:27 AM it was noted that there were quarantine PPE storage cabinets in the corridors outside of the following resident rooms. LVN #1 stated these residents came in contact with the COVID positive staff member (CNA #3) recently: room [ROOM NUMBER] (Resident #4), room [ROOM NUMBER] (Resident #5), room [ROOM NUMBER] (Resident #6 and #7), room [ROOM NUMBER] (Resident #8 and #9) and room [ROOM NUMBER] (Resident #10). She stated regarding Resident #11, She's not on isolation. -On 7/29/20 at 10:50 AM an observation was made of room [ROOM NUMBER] and it was noted that there was a disposable gown on the chair near the door. This disposable gown was outer side down, on top of a mechanical lift sling. On 7/29/20 at 12:14 PM at room [ROOM NUMBER] it was noted that there were two disposable gowns on a chair in the room. There was no identification on the gowns as to who they belonged to. These gowns were on top of the mechanical lift sling in the chair and next to red biohazard boxes. At this time CNA #1 stated related to the gowns, One in the chair is mine and the other is LVN #2's. On 7/29/20 at 11:30 AM in room [ROOM NUMBER] there were as a disposable gown in the seat of a chair crumpled with no identification. There was a face shield on top of bagged medical equipment on a shelf near the entrance. The face shield was face down with no identification on it. On 7/29/20 at 12:10 PM CNA #1 was asked about the disposable gown in the chair in room [ROOM NUMBER]. She stated, I've been in and out with Resident #2. It's my gown. It was noted at this time this gown again was in a chair on the A bed side. Also, at this time LVN #1 stated, Each staff member has their own gown. When asked about the equipment underneath the face shield on the shelf she stated, Those are his (Resident #2's)[MEDICAL CONDITION] kits. She was unable to determine if the face shield was clean or soiled. The face shield was stored on top of the bag [MEDICAL CONDITION] with the outside face portion down on top of them. -On 7/29/20 at 3:45 PM in room [ROOM NUMBER] Resident #1 was in bed A. The resident had [MEDICAL CONDITION] [DEVICE]. Resident #2 was in bed B and also had [MEDICAL CONDITION] [DEVICE]. Resident #1's over bed table had a box of T-drain sponges, [MEDICAL CONDITION] and an N 95 mask on it. There was no staff in the room. The package containing the (Gentlecare)[MEDICAL CONDITION] tubing had been placed on top of the N95 mask. The outside of the mask was facing up. -On 7/29/20 at 3:50 PM room [ROOM NUMBER] had a PPE supply storage cart outside of the room. There was a used surgical facemask on top of the cart with the interior of the mask facing up. It was also noted that there was a box of extra-large gloves stored on top of this mask. The facemask was noted to be used because it was pinched and formed at the nose/bridge area and the pleats were fully expanded out. -On 8/11/20 at 3:58 PM it was also noted in the small dining room that there was a cloth mask hung on the wall cabinet lower door in the small dining room. Also, in the small dining room there were two face shields left face down on the counter that were soiled with white spots and splatter along the bottom and had no names on them. One of the two face shields had bent plastic portion on both sides. On 8/11/20 at 4:34 PM 2 unlabeled and soiled face shields were observed again face down on the counter in the small dining room. On 8/11/20 at 4:36 PM CNA #4 was asked who these two face shields belong to. She stated, I don't know. >Communication of Resident Quarantine Status Inadequate On 8/11/20 at 5:35 PM an interview was conducted with the DON. At that time, she identified Residents #11, #14 and #15 as being quarantined. She added that Resident #15 was admitted on [DATE]. -On 8/12/20 at 8:55 AM in the small dining room Resident #11 was served her meal on a regular dishware tray. There was no service on Styrofoam/disposable dishware in this dining area. Record review of the nurse notes revealed that on 7/28/20 Resident #11 was readmitted to the facility (room [ROOM NUMBER]) from another nursing facility. -On 8/12/20 at 12:15 PM an observation was made of the dementia unit. All the residents were served on regular dishware trays in the lobby/dining room, including new admissions Residents #16 and #17. Record review of the face sheet revealed that Resident #17 (8/11/20) was admitted to the facility from the community. Interview with the DON on 8/12/20 at 4:05 PM revealed Resident #16 (8/08/20) was admitted from home. On 8/12/20 at 12:17 PM an interview was conducted with the Dietary Manager regarding the quarantine residents in the facility. She stated, For all of them everything is paper (Styrofoam/disposable). When asked who the quarantine residents were, she stated, Residents #11, #14 and #15? She was then asked how she received information as to who was quarantined and who was not. She stated, I get the information in the morning meetings. I thought that the paper (disposable) service was for hospital readmits only. She was not aware that Resident #16 and #17 were new admissions that were on quarantine. -On 8/12/20 at 12:55 PM Resident #14 had a regular dishware meal tray (non-disposable dishware) in her room and a noon meal

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) tray that was Styrofoam/disposable on her over bed tray table. Record review of the nurse notes revealed that on 8/10/20 Resident #14 was readmitted to the facility (room [ROOM NUMBER]) from another nursing facility. >Infection Control Noncompliance - Interviews On 8/11/20 at 4:45 PM an interview was conducted with the Assistant Administrator regarding their noncompliance in infection control. The she was asked, how do you think this incident, IJ, came about? She stated, Policies were not followed. They were not following the guidelines. On 8/11/20 at 5:40 PM an interview was conducted with the DON regarding their noncompliance in infection control. When asked how she thought this incident, IJ, came about? She stated, Laziness. Not thinking. They were not thinking a face shield would be contaminated when stored on objects. We had too many (quarantined residents) that needed assistance with eating in the small dining room. >Policy: Record review of the facility policy labeled Infection Prevention and Control Program, revised April 2020, revealed the following documentation, Policy Statement. An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Record review of the facility policy labeled Isolation - Categories Of Transmission Based Precautions, Revised January 2012, revealed the following documentation, Policy Statement. 1. Standard precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infectious status. Transmission based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others . Policy Interpretation and Implementation. 1. Transmission based precautions will be used whenever measures more stringent than standard precautions are needed to prevent or control the spread of infection. 2. Based on CDC definitions, three types of transmission-based precautions (airborne, droplet and contact) have been established . Droplet precautions. 1. In addition to standard precautions, implement droplet precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets . They can be generated by the individual coughing, sneezing, talking or by the performance of procedures such as sectioning . 4. Masks. a. In addition to standard precautions, put on a mask when entering the room or cubicle. 5. Resident transport. a. Limit movement of Resident from the room to essential purposes only. b. If transport or movement from the room is necessary, place a mask on the infected individual and encourage the resident to follow respiratory hygiene/cough etiquette to minimize dispersal of droplets . Record review of the current facility COVID-19 Plan revealed a document labeled Sequence for Putting on Personal Protective Equipment (PPE). The document stated, . 2. Mask or respirator. Secure elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Fit check respirator . www.cdc.gov/coronavirus . Record review of the current facility COVID-19 Plan revealed a document labeled How To Remove Personal Protective Equipment PPE Example 1. There are a variety of ways to safely remove PPE without contaminating your clothes, skin, or mucous membranes with potentially infectious materials . 4. Mask or respirator. Front of mask/respirator is contaminated - DO NOT TOUCH! If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer. Grasp bottom ties or elastics of the mask/respirator then the ones at the top and remove without touching the front. Discard in a waste container .CDC. Record review of the current facility COVID-19 Plan revealed a document labeled Do's and Don'ts for wearing N 95 respirators in non-surgical healthcare settings . Don't . Don't touch the front of the N 95 respirator as it is contaminated after use don't snap the straps as they may spread germs. Don't share your N95 respirator with others; germs can spread that way. Don't leave an N 95 respirator hanging around your neck . APIC (APIC Association for Professionals in Infection Control and Epidemiology) . Record review of the Personal Protective Equipment PPE Competency Validation Form, included in the facility's COVID-19 Plan revealed the following, Donning and doffing of personal protective equipment . Checklist. Donning PPE . 3. Don gown: fully covering torso from neck to knees, arms to end of wrist, wraps around back. 4. Tie/fasten in back of neck and waist . 5. Don Mask/Respirator . 7. Fit snug to face and below chin . Doffing PPE . 21. Remove mask/respirator . Grasp bottom, untie lower ties first and upper ties last. Avoiding touching front of mask/respirator. 22. Discard waste in appropriate garbage or if applicable store mask for reuse per facility policy . b. Respirator/facemask should be extended under chin. Both mouth and nose should be protected . Record review of the current facility COVID-19 Plan revealed a document labeled Do's and don'ts for wearing procedure mask in non-surgical healthcare settings . Don't. Don't reuse; toss it after wearing once . Record review of the in-service documentation attached to the facility's plan of removal dated 8/12/20 revealed an in-service given to staff labeled Admit/Readmit of COVID Positive Residents. Attached to the in-service sign in sheet was the policy reviewed labeled Draft Policy and Procedure: COVID-19 testing residents admitted from hospitals during COVID-19 pandemic. The policy documented the following, . Purpose. Provide guidance to nursing facility administration regarding COVID-19 testing and making decisions about excepting hospital discharges to their facility during a COVID-19 pandemic . Policy. During the resident referral process, the COVID-19 status of referred residents will be requested from the hospital or the referring physician. If the resident is admitted without testing, the director of nursing (or designee) will obtain physician orders to proceed with COVID-19 testing upon admission . Record review the facility policy labeled Policy: Isolation Precautions for COVID-19, Policy: 11.005, Date Revised: April 10, 2020, revealed the following documentation, Policy: to ensure that cross-contamination does not occur due to contaminated dishware and utensils, residents testing positive for COVID-19 will be served using disposable serving ware and in their rooms. If disposables are not available, the facility will ensure that plates, cups, trays, and/or utensils have been properly disinfected after usage. Procedure: 1. Nutrition and foodservice will prepare meals and place the designated menu items on disposable plates, cups, napkins, and bowls all meals. Plastic utensils will be sent . 6. All food items entering the room at meal time should be thrown away in the resident's room after completion of the meal. Nothing should leave the COVID-19 positive resident's room and return to the dining area our kitchen . The Assistant Administrator was notified of an immediate jeopardy on 8/11/20 at 3:23 PM. The Plan of Approval was accepted on 8/12/20 at 3:03 PM detailing the following: Plan of Removal Please accept this Plan of Removal as a credible allegation of compliance for immediate jeopardy initiated on August 11, 2020 for failure to 1) Follow CMS and CDC guidance addressing infection control to prevent the development and spread of COVID-19. 2) The facility failed to follow CMS guidance for long-term care facilities regarding ensuring quarantine measures were followed for residents with signs and symptoms or exposure to COVID-19. 3) Prevent co-mingling of quarantined and non-quarantined residents in a common area. 4) Store and dispose of soiled linens/clothing and refuse in a manner to prevent the spread of infections. 5) Don PPE (personal protective equipment) in a manner to prevent the transmission of infections 6) Store PPE in a manner to prevent contamination of the PPE, resident use equipment and/or its surroundings. 7) Handle or transport linen in a manner to prevent the spread of infections. 8) The facility failed to ensure effective prevention of the development and spread of COVID-19, as evidenced by observations of residents in the small dining room, other resident common areas observed and observations of resident rooms. Corrective Actions: 1. Action: On August 11, 2020 an in-service was conducted with the Director of Nursing regarding (PPE) the requirement for all nursing facility personnel to wear a facemask as well as required PPE at all times while inside the center, following the infection control to prevent the development and spread of COVID-19, and to follow the guidance of CMS and CDC for long-term care facilities regarding ensuring quarantine measures are followed for residents with signs and symptoms exposure to COVID-19. Completed 08/11/2020 2. Action: On August 11, 2020 an in-service was initiated by the Director of Nursing on guidance CMS and CDC infection control prevention and spread of COVID-19. The in-services will continue each shift to ensure all staff has the training. This in-service will include the requirement to notify the charge nurse, DON and the MD to ensure the obtaining of the appropriate surveillance, protection/PPE, Isolation, communication, and evaluation of residents. Validation of understanding is being accomplished by the Director of Nursing conducting random staff interviews to ensure understanding of procedure and/or guidance of CMS and CDC on prevention the development of COVID-19 and/or CMS guidance for long-term care facilities regarding ensuring quarantine measures are followed for residents with signs and symptoms or exposure to COVID-19. Any identified issues/concerns will be addressed immediately at that moment as corrective action. No staff will be allowed to work until their in-service is completed. The Director of Nursing or designee may conduct the in-services in person or on the phone. Initiated: 08/11/2020 Completion Date 08/13/2020 then on-going. 3. Action: On August 11, 2020 an in-service on CMS and CDC addressing infection control guidance was initiated with staff on preventing co-mingling of quarantined and non-quarantined residents in a common area. The in-services will continue each shift to ensure all staff has the training. The Director of Nursing or designee may conduct the in-services in person or on the phone. No staff will be allowed to work until their in-service is completed. Completion date: August 13, 2020 and on-going. 4. Action: On August 11, 2020 an in-service on Biohazard waste/linens, and linen infection control was initiated with staff on isolation, discontinuing, storing and disposing of soiled linens with the infection prevention and control program. Sugar bags are provided and will be used in place of the yellow isolation bags to help prevent the spread of COVID-19. The in-services will continue each shift to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455940	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LUBBOCK HOSPITALITY NURSING AND REHABILITATION CEN	**4710 SLIDE RD LUBBOCK, TX 79414**

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) ensure all staff has the training. The Director of Nursing or designee may conduct the in-services in person or on the phone. No staff will be allowed to work until their in-service is completed. Completion date: August 13, 2020 and on-going. 5. Action: On August 11, 2020 an in-service on Handling of Quarantined residents was initiated with staff on donning and doffing of PPE to prevent the spread of COVID-19. The in-services will continue each shift to ensure all staff has the training. The Director of Nursing or designee may conduct the in-services in person or on the phone. No staff will be allowed to work until their in-service is completed. Completion date: August 13, 2020 and on-going. 6. Action: On August 11, 2020 an in-service was initiated with staff on storing PPE in a manner to prevent contamination of the PPE, resident used equipment and/or it's surroundings. The in-services will continue each shift to ensure all staff has the training. The Director of Nursing or designee may conduct the in-services in person or on the phone. No staff will be allowed to work until their in-service is completed. Completion date: August 13, 2020 and on-going. 7. Action: On August 11, 2020 an in-service was initiated with staff on handling and transporting linen in a manner to prevent the spread of infections. The in-services will continue each shift to ensure all staff has the training. The Dire