STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675478	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRAIRIE HOUSE LIVING CENTER	**1301 MESA DR PLAINVIEW, TX 79072**

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to implement it's written policy and procedures that prohibit abuse and neglect for 1 of 8 residents (Resident #1) reviewed for neglect. The facility failed to report an allegation of neglect involving Resident #1 to the State Survey Agency within 24 hours of the allegation being made. This failure could affect residents by placing them at risk of not having incidents of abuse, neglect, exploitation, and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and State Survey Agency. The Findings Include: Record review of facility provided policy titled Abuse Policy, dated 2/2005, revised 9/13/2017 reflected in part: b. Each covered, individual shall report immediately, but no later than 2 hours after forming the suspicion, it the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. Fundamental Information Record review of Resident #1's clinical record revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's MDS, dated [DATE], revealed she had a BIMS score that could not be assessed. Staff assessment revealed severe cognitive impairment. The MDS indicated she required extensive assistance from staff with all ADLs. Record review of the incident report involving Resident #1 revealed that a fall with injury occurred on 7/28/20, and the facility was made aware of the allegation, on 7-28-2020 around 7:30 PM. The incident report showed Resident #1 had an unwitnessed fall, that she was assessed by staff, and neuros were initiated. The document further indicated that the facility did not report the incident to the State Survey Agency. No other documentation was found that indicated the facility alerted the State Survey Agency of the allegation of neglect. During an interview with DON on 8-11-2020 at 11:30 AM, she confirmed that Resident #1 had a fall with injury on 7-28-2020. DON stated that while the fall was not witnessed by a staff member, the fall was recorded on the surveillance camera located in the dining room. DON explained that the resident was in the dining room and leaned forward and fell over. She stated that the resident was found and assessed with [REDACTED]. DON stated that hospice asked to see resident before sending her to the hospital. DON stated that after being assessed it was determined that the resident did not need to go to the hospital. DON was asked if Resident #1 had any injuries as a result of the fall. DON stated that according to the report, there was a small laceration that did not require stiches, and that the laceration had already stopped bleeding by the time of the assessment. She also stated there was some swelling and bruising to the forehead. DON was then asked why she did not report the fall with injury to the State Survey Agency. She stated that she did not think that the injury was significant enough to report. DON was then shown the provided pictures of Resident #1 from the funeral home. It showed significant bruising and swelling of the face and forehead. The DON then stated that she thought that only significant injuries had to be reported. Surveyor stated that significant injuries needed to be reported within 2 hours, and that this injury should have been reported within 24 hours. DON confirmed that the fall should have been reported within 24 hours.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were reported to the administrator of the facility and to other officials (including to the State Survey Agency) within 24 hours after the allegation was made in accordance with State law for 1 of 8 residents (Resident #1) reviewed for abuse/neglect. The facility failed to report an allegation of neglect involving Resident #1 to the State Survey Agency within 24 hours of the allegation being made. This failure could affect residents by placing them at risk of not having incidents of abuse, neglect, exploitation, and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and State Survey Agency. The Findings Include: Record review of Resident #1's clinical record revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's MDS, dated [DATE], revealed she had a BIMS score that could not be assessed. Staff assessment revealed severe cognitive impairment. The MDS indicated she required extensive assistance from staff with all ADLs. Record review of the incident report involving Resident #1 revealed that a fall with injury occurred on 7/28/20, and the facility was made aware of the allegation, on 7-28-2020 around 7:30 PM. The incident report showed Resident #1 had an unwitnessed fall, that she was assessed by staff, and neuros were initiated. The document further indicated that the facility did not report the incident to the State Survey Agency. No other documentation was found that indicated the facility alerted the State Survey Agency of the allegation of neglect. During an interview with DON on 8-11-2020 at 11:30 AM, she confirmed that Resident #1 had a fall with injury on 7-28-2020. DON stated that while the fall was not witnessed by a staff member, the fall was recorded on the surveillance camera located in the dining room. DON explained that the resident was in the dining room and leaned forward and fell over. She stated that the resident was found and assessed with [REDACTED]. DON stated that hospice asked to see resident before sending her to the hospital. DON stated that after being assessed it was determined that the resident did not need to go to the hospital. DON was asked if Resident #1 had any injuries as a result of the fall. DON stated that according to the report, there was a small laceration that did not require stiches, and that the laceration had already stopped bleeding by the time of the assessment. She also stated there was some swelling and bruising to the forehead. DON was then asked why she did not report the fall with injury to the State Survey Agency. She stated that she did not think that the injury was significant enough to report. DON was then shown the provided pictures of Resident #1 from the funeral home. It showed significant bruising and swelling of the face and forehead. The DON then stated that she thought that only significant injuries had to be reported. Surveyor stated that significant injuries needed to be reported within 2 hours, and that this injury should have been reported within 24 hours. DON confirmed that the fall should have been reported within 24 hours. Record review of facility provided policy titled Abuse Policy, dated 2/2005, revised 9/13/2017 reflected in part: b. Each covered, individual shall report immediately, but no later than 2 hours after forming the suspicion, it the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. Fundamental Information
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 for 3 of 8 Residents (Resident #2, Resident #3, and Resident #4). - The facility failed to separate COVID positive and presumptive positive residents within the locked unit. This failure

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) resulted in an identification of an Immediate Jeopardy (IJ) on 8-8-2020 at 5:55 PM. While the IJ was lowered on 8-12-2020 at 11:30 AM, the facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems. Findings include: During an interview with LVN B on 8-8-2020 at 10:29 AM, she stated that she has symptomatic residents in the locked unit who have not been moved to the COVID unit. LVN B stated that the DON advised her to treat the symptoms of COVID and that no residents will be tested per corporate. LVN B stated that the only way she has found out that her residents are positive is when she sends them to the ER due to symptoms and they test positive at the ER. LVN B then said that the facility is not moving presumptive positive residents to the presumptive unit. She was asked why she thought that was, and she replied that she was just doing what the DON had told her. During an interview on 8-8-2020 at 12:20 PM, DON was asked about when to test a resident for COVID. DON stated that CCRN told her that the facility was a non-testing-based facility. DON stated that she was told to treat symptoms and if anybody gets worse to send them to the hospital. She was asked if residents who were symptomatic should be quarantined. She responded that they should be. She was then asked why residents in the locked unit were not quarantined. She responded that she didn't believe that the residents in the locked unit would be ok to be in a different area. During an observation of the locked unit on 8-8-2020 at 1:42 PM, there were no signs posted on the doors leading into the locked unit stating that anyone was on droplet-precautions, or that there were presumptive positive residents in the unit. Inside the unit, there were no signs posted on any resident doors stating isolation precautions or COVID status. There were no partitions separating presumptive positives or any quarantine measures in place in the locked unit. There was no PPE at hand near any rooms. There were no residents out in the common area. Most residents were seen in their rooms. Residents showed general symptoms of malaise such as lethargy. Some residents appeared asleep while others showed signs of discomfort such as facial grimacing and looking drawn. Coughing and vomiting could be heard from the hallway. During an interview with LVN B on 8-8-2020 at 1:45 PM, LVN B confirmed that Resident #3 was sent to the hospital on 8-5-2020, and in the ER tested positive for COVID. Resident #3's roommate, Resident #2, was not placed on any isolation precautions and later became symptomatic. LVN B stated 3 days after Resident #3 tested positive, Resident #2 was sent to the hospital where she was found to be positive for COVID. LVN B also stated the room was not sanitized after Resident #3 was found to be positive. LVN B stated that Resident #2 was not moved to another room, and that there was no attempt to isolate her. LVN B stated that now the entire unit is not feeling well. She stated that all the residents are eating less the past 2 days and are fatigued, with many of the residents having a cough. LVN B stated that she believed she would be sending more residents, especially Resident #4, to the hospital that day. LVN B stated that she had sent out Resident #2 that morning after taking report at 6:00AM due to signs of COVID 19 (N/V/D, Headache, Lethargy). LVN B was asked to show surveyor Resident #3's and Resident #2's room. There was no warning sign in place stating that a COVID positive or presumptive positive resident was in this room. The room had obviously not been cleaned as evidenced by the dirty laundry and general unkemptness of the room. LVN B was asked and confirmed that Resident #2 was not moved to another room after Resident #3 tested positive for COVID on 8-5-2020. She confirmed that the room was not cleaned. LVN B confirmed that there was no attempt to place Resident #2 on any type of isolation precaution. LVN B then confirmed that Resident #2 had interacted with most other residents in the locked unit after her roommate, Resident #3 tested positive for COVID-19. LVN B was then asked why she did not attempt to place presumptive positive residents on isolation precautions. She stated that she was just following what the DON had told her to do. When asked why the room was not cleaned she stated she was told they had to wait 72 hours after a resident tested positive to clean the room with EPA cleaner that killed COVID. LVN B was then asked if she thought that was safe for the residents, she replied no but she was just doing what she was told. During an observation of the locked unit on 8-8-2020 at 2:30 PM, Resident #4 had no sign on her door stating that she was a presumptive positive resident due to symptoms. During this observation, Resident #4 was leaving the facility via ambulance to be taken to the ER for evaluation due to exhibiting signs and symptoms of COVID-19. During an interview on 8-8-2020 at 3:29 PM, DON was asked if the facility had any mitigation strategies for the locked unit for separating residents who were showing signs of COVID-19. DON confirmed that the facility did not have any mitigation strategies in place to separate presumptive residents from non-presumptive in the locked unit. She confirmed that residents who were exposed to COVID should have been isolated as much as possible in the locked unit and should have been placed on droplet precautions. DON confirmed that there were no signs posted on any resident doors stating the need for isolation, even though some residents were symptomatic. DON confirmed that Resident #3 was sent to the hospital on 8-5-2020 where she was found to be positive for COVID. DON confirmed that her roommate, Resident #2, was not moved out of the room they shared, was not placed on isolation precautions, and did not have their room cleaned after Resident #3 tested positive for COVID. During an interview with the ADM on 8-8-2020 at 5:50 PM, she was asked why there was no effort to separate the presumptive positive cases within the locked unit. ADM stated that they had moved a locked unit resident off the unit and into a COVID positive unit and it had been very difficult for the resident and staff alike. ADM was asked why she did not try and separate presumptive positive residents from healthy residents back in the locked unit itself, and then was asked if she believed that Resident #2 should have been moved to another room at the very least. She responded that they should have moved Resident #2 to a different room and placed her on droplet precautions and confirmed that they did not. She was then asked why there was no attempt to place residents with signs of COVID on isolation precautions. ADM responded that it would have been very hard to keep residents in their rooms but agreed and confirmed that an honest attempt was not made. ADM confirmed that no signs were placed anywhere on the unit alerting anyone to possible COVID exposure. DON also confirmed that Resident #3's room was not cleaned after she was found to be positive for COVID-19. Record review of Resident #2's clinical record revealed an [AGE] year-old female resident admitted to the facility on [DATE] with a primary [DIAGNOSES REDACTED].#2's MDS, dated [DATE], revealed a BIMS score that could not be assessed. The staff assessed Resident #2 as severely cognitively impaired. Section GG of the MDS revealed that the resident was able to ambulate within the locked unit independently. Record review of Resident #3's clinical record revealed a [AGE] year-old female admitted to the facility on [DATE] with a primary [DIAGNOSES REDACTED].#3's MDS, dated [DATE], revealed a BIMS score of 5. Section G of the MDS revealed that the resident was able to ambulate with supervision. Record review of Resident #4's clinical record revealed a [AGE] year-old female resident admitted to the facility on [DATE] with a primary [DIAGNOSES REDACTED].#4's MDS, dated [DATE], revealed a BIMS score of 6. Section G of the MDS revealed that she was able to ambulate independently in her wheelchair. Record review of facility provided policy titled Surveillance Plan: Infection Control Surveillance COVID-19, dated 1-30-2020, revised 6-2-2020, reflected in part: Fundamental Information Isolation Precautions are implemented for residents with known or suspected COVID-19 in a private room (if available), or other actions taken based on national (e.g., CDC), state, or local health authority recommendations. Patient Placement -Resident that is presumptive or COVID-19 positive will immediately be placed in a Private Room or cohorted (if private room no available) with the door closed in the designated area and implement Droplet/Contact Isolation Precautions. - Any roommates exposed to COVID-19 should be moved to a designated area and monitored for COVID-19 symptoms three times daily for 14 days. Room-sharing might be necessary if there are multiple resident with unknown or suspected COVID-19 in the facility. Infection Control Measures - If the resident has fever or symptoms, implement recommended infection prevention and control measures. Record review of Nursing Facility COVID-19 Response Emergency Rule, not dated, reflected in part: f) A nursing facility must cohort residents based on the residents' COVID-19 status. Record review of facility provided policy titled Surveillance Plan: Infection Control Surveillance COVID-19, dated 1-30-2020, revised 6-2-2020, reflected in part: Signage - Place signs to notify individuals entering the room to talk with nurse prior to room entry - Signage on the use of specific PPE (for staff) posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide) The ADM was notified of the Immediate Jeopardy (IJ) on 8-8-2020 at 5:55 PM. The ADM was emailed a copy of the completed Immediate Jeopardy (IJ) template. ADM verified that she received the template via email. On 8-10-2020 at 10:14 AM the facility provided a plan of removal and it was accepted on 8-10-2020 at 11:30 AM. It documented the following: Plan of Removal Infection Control Prairie House Living Center This plan of removal serves as Prairie House Living Center's response to the Immediate Jeopardy notification the Center received at 5:55 PM on August 8, 2020 from the Texas Department of Aging and Disability related to: - Center failed to follow CMS and CDC guidelines addressing infection control to prevent the development and spread of COVID-19 to prevent the potential spread of COVID-19. - The facility failed to follow CMS guidance for LTC facilities regarding cohorting (positive and negative residents with COVID-19. - The facility failed to ensure isolation/quarantine measures were followed for residents with signs and symptoms or exposure to COVID-19 1. Immediate action(s) taken for the resident(s) found to have been affected include: - On 8/8/2020 all residents were assessed by DON and physician via telehealth for each resident in the TLC unit to determine if any residents were

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) displaying signs and symptoms of COVID-19 - 22 residents were identified as having COVID 19 signs and symptoms. 22 residents from the TLC unit were identified. - 3 residents on the TLC unit were transferred to hospital on [DATE]. - 16 of the 22 residents remained on the TLC unit which was converted into a presumptive unit on 8/8/2020 with all residents in contact-droplet precautions. - On 8/9/2020 RNC validated using the unit assessment form the COVID positive unit and both Presumptive units have dedicated staff. - On 8/8/2020 all other residents in center on south, north, and med hall were assessed by DON and ADON using infection control monitoring tool to determine if any other residents were displaying signs and symptoms of COVID-19. No other residents were identified as having COVID-19 symptoms. This was completed 8/8/2020. - On 8/8/2020 ADM made complete room rounds on TLC unit and all other units to validate that any resident that is displaying signs of COVID-19 were placed in droplet-contact precautions. - On 8/8/2020 ADM made complete room rounds to validate roommate of symptomatic resident was separated and placed in droplet-contact isolation. This was completed on 8/8/2020. - On 8/8/2020 ADM, using a facility census, validated that any resident with COVID-19 symptoms or recently transferred to hospital had resident(s) room clean and sanitized using and EPA grade disinfectant. 2. Action to Prevent Occurrence/Reoccurrence: The following actions were taken to ensure occurrence or reoccurrence of process/system failure that could lead to serious adverse outcome and when those actions were completed. - 1:1 education was completed on 8/8/2020 with ADM and DON via phone with RDO and RNC on relocation and placing in droplet-contact precautions, any resident displaying symptoms of COVID-19 and separating exposed roommates of symptomatic residents and placing in droplet-contact isolation. Post-test was completed. - In service education was started on 8/8/2020 by ADON and DON on S/S of COVID-19 to all staff including CNAs. This education will continue until 100% of all staff is completed. Post-test will be completed to validate knowledge base. Education and Post Tests will be completed on 8/8/2020 and any staff that has not had this education will not be allowed to return to work until this is completed. Post-test was completed. - In service education was started on 8/8/2020 by ADON and DON for all nurses and CNAs on protocol of relocating residents who display S/S of COVID-19, on protocol regarding separating roommates who had potential exposure to residents displaying S/S of COVID-19, or positive for COVID-19. This education will continue until 100% of nurses and CNAs are completed. Post-test will be completed to validate knowledge base. This education and Post Tests will be completed on 8/8/2020 and any staff that has not had this education will not be allowed to return to work until this is completed. - 1:1 education was completed on 8/8/2020 with ADM and DON via phone with RDO and RNC on ensuring that all rooms are cleaned with EPA grade disinfectant after a resident with symptoms of COVID-19/COVID positive/or any exposed resident, is identified and/or relocated to another area in the center. - On 8/9/2020 education was started with all staff including CNAs on ensuring that all rooms are cleaned with EPA grade disinfectant after a resident with symptoms of COVID-19/COVID positive/or any exposed resident, is identified and/or relocated to another area in the center. This education will be completed on 8/9/2020 and any staff that has not had this education will not be allowed to return to work until this is completed. - DON/designee using the QAPI monitoring tool for Infection Control will review infection control monitoring tool daily x 4 weeks to validate that any residents identified with COVID-19 symptoms or had a potential exposure were identified, evaluated, had family and physician notification, placed in droplet-contact precautions, and relocated in center in applicable. - DON/designee using the QAPI monitoring tool for PPE will validate daily x 4 weeks that donning and doffing area are running correctly, and that staff are donning and doffing PPE correctly. - Administrator/designee using the QAPI Environmental monitoring tool will validate daily x 4 weeks that all rooms are cleaned with EPA grade disinfectant after a resident with symptoms of COVID-19/COVID positive/or any exposed resident is identified and/or relocated to another are in the center. - Administrator and DON will daily in morning meeting will review resident assessment tools and identify potential exposure risk, relocating roommates and for continued observations and/or quarantine. - Administrator and DON daily will review unit assignment sheets for COVID unit and both Presumptive units to validate dedicated staff to each unit x 4 weeks. - Administrator and DON will review QAPI monitoring tools daily in morning meeting. - MD was notified on the Immediate Jeopardy 8/8/2020 at 8:05 PM. - This system will be reviewed in QAPI meeting to include the medical director and will be conducted on 8/8/2020 to discuss sustaining compliance. A QAPI meeting will be conducted monthly to monitor compliance. 3. Date facility asserts likelihood for serious harm no longer exist is 8/9/2020. During a visit on 8-11-2020 beginning at 9:15 AM to verify completion of the facility's Plan of Removal, the following observations, interviews and record reviews were completed: Observation of the locked unit revealed all rooms had signs for droplet-contact precautions as well as COVID signs posted on the doors. Each unit in the facility was labeled to tell what type of unit was partitioned off. Both Presumptive units had a donning and doffing area in place. Observed NF staff adherence to PPE donning and doffing techniques. Observed proper handwashing techniques by NF staff. Interviewed 8 staff members to include the DON, ADM, CCRN, 3 LVNS, and 2 CNAs, all of which could identify what type of residents were in each unit. All stated that they had received training on signs and symptoms of COVID-19, cohorting positive or presumptive positive residents, and cleaning infected rooms. Reviewed the assessments completed by the DON, ADON, and ADM. Reviewed the training that was provided the DON and ADM by their corporate office. Record review of training and post-tests for staff were completed. Review revealed that less than half of the staff had been trained on COVID issues. Interview with CCRN revealed a plan to have most of the staff trained within 24 hours. During an interview with CCRN on 8-11-2020 at 3:00 PM, she was asked how she planned on training all staff in a timely manner. She responded that no staff member would be allowed to clock in and work the floor until all training stated on the Plan of Removal had been completed. She stated that all staff currently working the floor had been trained prior to clocking in that morning. On 8-12-2020 at 9:45 AM, CCRN sent an updated list via email of all staff what had been trained according to their Plan of Removal. List revealed that the majority of all staff had been trained and had taken the post-test. Immediate Jeopardy was lifted on 8-12-2020 at 11:30 AM. The facility remained out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy identified as pattern due to the facility's need to evaluate the effectiveness of the corrective systems.