STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455643	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MATAGORDA HOUSE HEALTHCARE CENTER	**700 12TH ST BAY CITY, TX 77414**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**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 ensure an effective infection control program to help prevent the development and transmission of communicable diseases and infections was maintained for the facility for 12 (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12) of 102 residents reviewed for isolation. -The facility failed to social distance residents on the 300 Hall/Memory Care per the guidelines set by the CDC. -The facility failed to separate11 residents on isolation from the general resident population per guidelines set by the CDC for untested residents. -The facility failed to ensure PPE was available at the Isolated Residents rooms for staff to use. These failures could affect all residents and placed them at risk of exposure to contagious infections that could cause illness and/or death. Findings included: Resident #1 Record review of Resident #1's face sheet revealed she was a [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS dated [DATE] revealed she has a BIMS score of 15 indicating cognitively intact and independent with ADL's. Record review of Resident #1's Care Plan dated 3/14/20 revealed she was at risk for psychosocial well-being related to restrictions of COVID-19 precautions. On 4/27/20 a care plan was written for droplet precautions due to recent hospitalization stay. Observation and Interview on 5/5/20 at 9:41 a.m. with Resident #1 in her room on 200 hall. There was a sign on the door indicating isolation precautions and use of PPE before entering room. There was a 3-tier plastic bin on the outside of the room with gloves, plastic aprons, masks and biohazard bags. Inside the room there was a yellow and a red biohazard bin. The resident said she went to the hospital on [DATE] for a blood transfusion and had been in isolation ever since. She said she was not tested at the hospital for COVID-19 and had no signs or symptoms of illness. Resident #2 Record review of Resident #2's face sheet revealed she was a [AGE] year-old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. Her room was on 200 hall. Record review of Resident #2's MDS dated [DATE] revealed she had a BIMS score of 8 indicating moderately impaired cognition and limited help with ADL's. Record review of Resident #2's Care Plan dated 2/2/20 revealed she was at risk for droplet precautions due to community [MEDICAL TREATMENT]. Resident #3 Record review of Resident #3's face sheet revealed she was a [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #3's MDS dated [DATE] revealed she had a BIMS score of 10 indicating moderate cognitive impairment and independent with ADL's. Record review of Resident #3's Care Plan dated 4/8/20 revealed she was at risk for psychosocial well-being related to restrictions of COVID-19 precautions. Resident #3 received [MEDICAL TREATMENT] three times a week and was at risk for increased shortness of breath, chest pains, and blood pressure. Observation of Resident #2 and #3 on 5/5/20 at 9:53 a.m. revealed they were in the same room on the 200 hall. The room was located between resident rooms who were not on isolation on the hall. There was a sign on the door indicating contact isolation precautions and use of PPE before entering room. There was a 3-tier plastic bin on the outside of the room with gloves, plastic aprons, masks and biohazard bags. Inside the room was a yellow and red biohazard bin located near the bathroom. Resident #4 Record review of Resident #4's face sheet revealed she was a [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #4's MDS dated [DATE] revealed she had a BIMS score of 4 indicating severe cognitive impairment and dependent with ADL's. Record review of Resident #4's Care Plan dated 4/1/20 revealed she was at risk for psychosocial well-being related to restrictions of COVID-19 precautions. She received [MEDICAL TREATMENT] three times a week and was at risk for increased shortness of breath, chest pains, and blood pressure. Observation on 5/5/20 at 11:43 a.m. of Resident #4 in her room in the middle of 300 hall/Memory Care Unit. There was a sign on the door indicating she was on contact isolation. Inside her room there was a yellow and a red biohazard bin located near the bathroom. The door sign indicated there were 2 residents (Resident #12) who resided in that room and were on isolation precautions. Observation and Interview on 5/5/20 at 11:49 a.m. with LVN B on 300 hall, she said 300 hall was a Memory Care Unit. She said Resident #4 was the only resident on contact isolation because of frequent off-campus [MEDICAL TREATMENT] visits. She said Resident #4 and her roommate Resident #12 were on contact isolation together because there were no other rooms on the Memory Care Unit for Resident #4 to have her own room. Resident #5 Record review of Resident #5's face sheet revealed he was a [AGE] year-old male admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #5's MDS dated [DATE] revealed he had a BIMS score of 15 indicating cognitively intact and independent with most ADL's. Record review of Resident #5's Care Plan dated 3/24/20 revealed he was at risk for droplet precautions due to community appointments. Observation on 5/5/20 at 10:43 a.m. Resident #5's room was on 400 hall. The door was closed with a sign on the door indicating isolation precautions and use of PPE before entering room. There was a 3-tier plastic bin on the outside of the room with gloves, plastic aprons, masks and biohazard bags. Resident was alone and asleep in bed. Resident #6 Record review of Resident #6's face sheet revealed she was an [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #6's MDS dated [DATE] revealed her BIMS score of 5 indicating severely cognitively impaired and needed extensive assistance with ADL's. Record review of Resident #6's Care Plan dated 4/24/20 revealed she was at risk for droplet precautions due to recent hospitalization stay and should follow CDC precautions. Observation on 5/5/20 at 10:45 a.m. of Resident #6's room revealed it was on 400 hall mixed-in with the residents not on isolation. The door was closed with a sign on the door indicating isolation precautions and use of PPE before entering room. There was a 3-tier plastic bin on the outside of the room with gloves, plastic aprons, masks and biohazard bags. Resident #7 Record review of Resident #7's face sheet revealed he was a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #7's MDS dated [DATE] revealed he was cognitively impaired and required extensive assistance with ADL's. Record review of Resident #7's Care Plan dated 5/4/20 revealed he was at risk for droplet precautions due to recent hospitalization stay and should follow CDC precautions. Care plan dated 12/20/19 revealed a risk for shortness of breath and respiratory distress/ failure and required oxygen and nebulizer treatments. Record review of Resident #7's HHSC's hospital to post acute care facility transfer - COVID-19 assessment completed on 4/2/20 and 4/30/20. Resident #7's primary reason for hospitalization was sacral wound infection. The form indicated the resident was not tested for COVID because he did not meet the CDC guidelines. Hospital staff signed off on 4/2/20 and 4/30/20 for clearance to discharge to the nursing facility. Record review of Resident #7's labs revealed a blood COVID test completed on 4/9/20 and results were negative. Observation on 5/5/20 at 10:46 a.m. of Resident #7's room on the 400 hall. The door was open with a sign on the door indicating isolation precautions and use of PPE before entering room. There was a 3-tier plastic bin on the outside of the room with gloves, masks and biohazard bags. Resident #8 Record review of Resident #8's face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #8's Care Plan dated 5/4/20 revealed she was at risk for psychosocial well-being related to restrictions of COVID 19 precautions. Record review of Resident #8's HHSC's hospital to post acute care facility transfer - COVID-19 assessment completed on 5/4/20. Resident #8's primary reason for hospitalization was status [REDACTED]. Hospital staff signed off on 5/4/20 so the resident could be discharged to the facility. Observation on 5/5/20 at 10:56 a.m. of Resident #7's room on the 400 hall. The door was open with a sign on the door indicating isolation precautions and use of

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) PPE before entering room. There was a 3-tier plastic bin on the outside of the room with gloves and biohazard bags. Observation and Interview on 5/5/20 at 11:03 a.m. with CNA A, she said some of the plastic bins next to a room did not have all the PPE that was needed to enter an isolated resident room. She said she was able to get the supplies she was needed from the other plastic bins scattered on the 400 hall. Observation of CNA A as she walked to the plastic container outside of Resident #6's room, she removed a plastic apron, put it on, and entered Resident #8's room. She said the PPE bins were restocked daily by the Infection Control Nurse or the Supply Coordinator. CNA A said she would tell the Infection Control Nurse to restock the PPE bins on the hall. Resident #9 Record review of Resident #9's face sheet revealed he was a [AGE] year-old male admitted on [DATE] and re-admitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #9's MDS dated [DATE] revealed he had a BIMS score of 12 indicating moderately impaired cognition and independent with most ADL's. Record review of Resident #9's Care Plan dated 3/14/20 revealed he was at risk for psychosocial well-being related to restrictions of COVID-19 precautions. On 3/21/20 the care plan was updated for end stage [MEDICAL CONDITION]. Resident #9 received [MEDICAL TREATMENT] three times a week and was at risk for increased shortness of breath, chest pains, blood pressure. Observation on 5/5/20 at 11:16 a.m. of Resident #9's room on the 400 hall. The door was open with a sign on the door indicating isolation precautions and use of PPE before entering room. There was a 3-tier plastic bin on the outside of the room with gloves and biohazard bags. Resident #10 Review of Resident #10's face sheet revealed she was a [AGE] year-old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #10's Care Plan dated 4/30/20 revealed she was at risk for droplet precautions due to recent hospitalization stay and should follow CDC precautions. Record review of Resident #10's HHSC's hospital to post acute care facility transfer - COVID 19 assessment completed on 4/30/20. Resident #8's primary reason for hospitalization was urinary tract infection, weakness, muscular [MEDICAL CONDITION] and upper respiratory infection. The form identified the resident was tested for COVID on 4/27/20 and test results was negative. Hospital staff signed off on 4/30/20 to discharge the resident to the facility. Resident #11 Record review of Resident #11's face sheet revealed she was an [AGE] year-old female admitted on [DATE] and re-admitted on [DATE]. Her [DIAGNOSES REDACTED]. Record review of Resident #11's MDS dated [DATE] revealed Resident #11 was cognitively impaired and required extensive assistance with ADLs. Review of Resident #11's Care Plan dated 4/28/20 revealed she was at risk for psychosocial well-being related to restrictions of COVID 19 precautions. Resident #12 Record review of Resident #12's MDS revealed she was an [AGE] year-old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. She had severe cognitive impairment and needed limited assistance with ADL's and supervision for eating. Observation on 5/5/20 at 11:43 a.m. of Resident #12's room in the middle of 300 hall/Memory Care Unit. There was a sign on the door indicating she was on contact isolation. Inside the room was a yellow and a red biohazard bin located near the bathroom. The door sign indicated there were 2 residents (Resident #4) who resided in that room and were on isolation precautions. Interview on 5/5/20 at 9:21 a.m. with DON, she said the facility had grouped most of the isolated residents on 400 hall but there were other residents on the other halls who were also on isolation. She said the facility had not grouped the isolated rooms to one hall because some of the families did not want to move their residents to a different area. She said management talked about moving the isolated residents all on hall 400 but that hall was a heavy traffic hall because of the rehab gym and laundry stationed down that hall. Interview on 5/5/20 at 9:34 a.m. with LVN A, she said her role at the facility was as the Infection Prevention Nurse. She said she had done training related to the COVID-19 and the new facility policy/procedures related to new infection control guidelines. She said most isolated residents were in their own room, except 5 residents. She said Resident #10 and #11 shared a room because they both returned from the hospital on [DATE]. She said Resident #2 and #3 were isolated together because they left the facility to go to [MEDICAL TREATMENT]. She said resident #4 had a roommate because there was no other rooms available for her or her roommate on the 300 hall/Memory Care Unit. She said the facility did designate the end of hall of 500 hall for quarantine in case any resident became COVID positive. She said she was not aware of the new guidelines to separate the isolated resident population from the general resident population. She said the residents who are on isolation are throughout the building. LVN A also said she was in charge of the PPE at the facility and dispensed the PPE as needed into the plastic bins if staff reported they were low. Interview on 5/7/20 at 12:44 p.m. with the Administrator, she said the residents on isolation returned from the hospital back to their room because some families did not want to change resident rooms. She said her expectations are for staff to follow CDC guidelines related to COVID-19. She said she was not aware residents on isolation should be separated from the rest of the resident population. Observation on 5/5/20 at 11:33 a.m. on the 300 hall/Memory Care Unit there were 13 residents and 4 staff in the dining room. One table had 3 residents with 1 staff assisting a resident with her meal. Another table had 3 residents eating lunch. There were 2 residents sitting side by side on a couch, and one resident eating her lunch. Interview on 5/7/20 at 8:42 a.m. with LVN B, she said she notified the management and the Infection Control Nurse of her concern of the residents on 300 Hall/Memory Care Unit being too close to each other. LVN A said the memory care residents were used to routine and it was difficult keeping them in their rooms during meals. She said she had discussed with management social distancing for the residents, but it was very difficult to maintain due to the residents' cognition. Observation on 5/7/20 at 12:05 a.m. revealed 11 residents finishing their meals in the dining room of 300 hall/Memory Care Unit. There were 3 staff in the dining room assisting the residents with their meals. Interview on 5/7/20 at 12:06 p.m. with the SLP who was assisting a resident on 300 hall/Memory Care Unit with her meal. He said the staff attempted to redirect residents back to their rooms for meals, but the residents kept wandering back into the dining room because they were used to that routine. He said social distancing was almost impossible with this population because of their dementia. Interview on 5/7/20 at 12:09 p.m. with LVN A, she said she was aware that LVN B had discussed the difficulty of 300 hall/Memory Care Unit residents social distancing. She said she did further training on that unit to prevent the residents from congregating in the dining room. Interview on 5/7/20 at 12:44 p.m. with the Administrator, she said she was not aware that residents were congregating in the dining room during meals on 300 hall/Memory Care Unit. She said her expectations were for staff to redirect and socially distance the residents. She said it was difficult to redirect these residents to their rooms because of the dementia. Interview on 5/7/20 at 1:07 p.m. with the DON, she said she had discussed with the corporate office the 300 hall/Memory Care Unit residents congregating in the dining room. She said her expectations were for the residents to remain in their rooms and not gather in the dining room during meals. She said because the residents on 300 hall had memory loss it was difficult to redirect them. Record review of the facilities policy and procedure for COVID-2019 Outbreak Standards of Practice, revision date of 4/17/20 read in part . The goal is to prevent the spread of COVID-19 in skilled nursing facility settings . Spread from person to person happens among close contacts (about 6 feet) . Social distancing is a set of non-pharmaceutical infection control actions intended to stop or slow down the spread of a contagious disease. The objective of social distancing is to reduce the possibility of contact between persons carrying an infection, and others who are not infected, so as to minimize disease transmission, morbidity and ultimately mortality . Communal dining, or the act of multiple individuals dining at the same table and or in the same dining area/ room creates a barrier to achieve social distancing . Our center will discontinue communal dining and work to devise dining delivery strategies that result in appropriate food delivery systems/ practices that help support the goal of social distancing . If common are of dining is utilized will need to make sure tables and patients are at least 6 feet apart . Record review of the facility policy and procedure Infection Control in Long-Term Care revised date of June 2005 read in part . The major purposes of infection control programs in the nursing facility are to minimize the effects of infections on residents and employees, and to educate the staff . Preventative measures should focus on appropriate isolation precautions, following established general and disease-specific guidelines such as those of the Centers for Disease Control .