STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676404	A. BUILDING _____ B. WING _____	05/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VISTA LIVING OF VERNON	4301 HOSPITAL DR VERNON, TX 76384

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** - 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 establish and 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 all residents. The facility failed to implement infection control prevention measures necessary to reduce the spread of infection by failing to ensure: (a) screening for symptoms of COVID-19 was being conducted at the entrance door, of persons entering the facility; (b) all entrance doors were being monitored to ensure staff and essential visitors were screened for symptoms of COVID-19, and dietary staff were not allowed to enter the facility through the kitchen door, which was not monitored; (c) facial masks were being worn, in a manner to protect themselves or others from the COVID-19 virus; (d) sufficient training and oversight was provided to facility staff during the COVID-19 pandemic; (e) facility staff who were not tested for COVID-19, during mass tested , were not allowed in the facility for at least 14 days or without proof of a negative test result, from an outside testing source; (f) residents who were not tested for COVID-19 (resident ID's #1 and #3) during mass testing and a new admission (resident ID #5) were isolated and were not allowed in common areas of the facility. An Immediate Jeopardy (IJ) was identified on 05/22/20. While the IJ was lowered on 05/29/2020, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of widespread, due to the facility's need to complete in-service training, monitor the implementation of their plan of removal, and evaluate the effectiveness of their plan of removal. This failure could place residents at a greater risk of being exposed to the COVID-19 virus and result in serious illness and/or death. The Findings included: (a) In an observation on 05/22/2020 at 5:18 pm a delivery person was not screened by facility staff and walked into the facility to the Nurses' Station with a dolly, and delivered numerous boxes before leaving the facility. This delivery person was not questioned about signs and symptoms of COVID-19, in any manner, at any time, during his visit to the facility. The delivery person did not have his temperature taken during this visit. An observation on 05/22/20 at 6:02 pm revealed this surveyor entered the facility without having his temperature taken or any screening questions asked, related to COVID 19 symptoms. Observation of a sign, posted on the front entry door, revealed the following: Stop. Entry Restricted to Essential Personnel. Mask Required for Entry. There were no signs related to screening for COVID-19. No staff were located at the entrance of the facility and the front door was unlocked. This surveyor was able to enter the facility, and walk through a common area, where 4 residents were present, to get to the Nurses' Station. There was a sign in sheet at the Nurses' Station, but no staff were ensuring compliance with visitors signing in, using alcohol-based hand rub, washing hands, or having their temperatures monitored. No monitoring of this surveyor was conducted. A staff member, present at the Nurses' Station assisted this surveyor with identifying RN A. In an interview on 05/22/20 at 6:12 pm with RN A, revealed the DON had just left the facility and the Administrator was out of town. RN A stated she would notify the DON of the surveyors' presence in the facility. RN A provided a telephone number, to reach the Administrator. The Administrator was contacted by phone at this time and stated she was out of town and would not be returning. She then stated, I've been there for 10 days in a row and need some time off. An observation on 5/22/20 at 6:30 pm revealed the surveyor was able to enter the facility without being screened for COVID 19 symptoms. The surveyor was able to enter the facility through the front door and walk past a common area to the Nurses' Station several feet away, with no screening conducted. There were 4 residents present in the common area.There was no screening area present at the entrance and no facility staff in the area, monitoring facility staff and visitors entering the facility. An interview on 05/22/20 at 8:00 pm, with the DON, revealed the facility had a staff shortage and was not able to designate a staff member to screen staff and visitors, at the entrance to the facility, for signs or symptoms of COVID-19. An observation on 05/23/20 at 12:10 pm, revealed the surveyor entered the facility without having his temperature taken or any screening questions answered, related to COVID 19 symptoms. The front door was unlocked, allowing entrance. There was a desk located near the entry way, with alcohol-based hand rub, a thermometer, and a COVID 19 sign in sheet. No staff were present in this area during this observation. An interview on 05/23/20 at 1:30 PM with the Office Assistant, revealed she was responsible for monitoring the front door. She stated the reason she was not at the front when this surveyor entered was because she was assisting on Hall D. An interview on 05/23/20 at 12:34 PM, with Dietary Staff D, revealed he was not screened at the entrance door, when entering the facility, but instead reported to the Nurses' Station to be screened. An interview on 05/25/20 at 2:02 PM, with Dietary Staff C, revealed she came through the front door of the facility but walked through a common area to the Nurses' Station to be screened. Dietary Staff C stated she was not screened, at the entrance to the facility, when entering the facility. Review of the COVID Response for Nursing Facilities, version 2.9, dated 05/19/2020, revealed the following: (in part) - It is important to note current CMS and state guidance to NFs requires they limit visitors to only those who are providing critical assistance and only if these essential visitors are properly screened. - Actively screen, monitor, and surveil everyone who comes into the facility. - Screen staff for signs and symptoms at least at the beginning of their shift - Protect from infection .Enact PPE plans o Screen residents/essential visitors - COVID-19 is most likely to be introduced into a facility by ill health care personnel (HCP) or visitors. Facilities must also restrict entry of non-essential personnel, and essential personnel should be screened for fever and symptoms before they enter the facility to begin their shift. - Essential services such as [MEDICAL TREATMENT], interdisciplinary hospice care, organ procurement, or home health personnel should still be permitted to enter the facility provided they are wearing all appropriate PPE and undergo the same fever and symptom screening process as facility staff. Facilities can allow entry of these essential visitors after screening. - Active screening - The CDC and CMS recommend NFs screen all staff prior to entering the facility at the beginning of their shift for fever and symptoms consistent with COVID-19. Actively take their temperature and document absence of or shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask, immediately leave the NF, and self-isolate at home. (b) An interview on 05/24/20 at 12:36 PM, with Dietary Staff B and D, revealed they had both been entering through the Kitchen door from outside of the facility and not going through the main entrance of the facility when arriving to work. They both stated they walked from the kitchen and through a common area to the Nurses' Station to be screened. An interview on 05/25/20 at 2:01 PM, with Dietary Staff E, revealed she had been going through the Kitchen door from outside of the facility and not going through the main entrance of the facility when arriving to the facility. She stated she walked from the kitchen and through a common area to the Nurses' Station to be screened. (c) Observations on 05/22/2020 revealed the following: - at 6:12 pm RN A was wearing a facial mask, incorrectly, leaving her nose exposed; - at 6:30 pm, two dietary staff were at the nurses' station, near the dining area with no facial masks on, leaving their mouths and noses exposed; - at 7:06 pm, two unidentified CNAs were sitting near the vending machines in the facility, with facial masks hanging from one ear, leaving their mouths and noses exposed. An observation on 05/24/20 at 12:35 PM, with Dietary Staff B, revealed the dietary staff was going through the kitchen door to the dining room area and was not wearing a facial mask, leaving their mouth and nose exposed. Review of the COVID Response for Nursing Facilities, version 2.9, dated 05/19/2020, revealed the following: (in part) - For the duration of the state of emergency, all NF

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 -** Many	(continued... from page 1) personnel should wear a facemask while in the facility. - Prevent spread of COVID-19: o Actions to take now: Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments. Ensure all HCP wear a facemask while in the facility. (d) An interview on 05/23/20 at 1:20 PM, with RN B and LVN A, revealed they had not received any training concerning COVID-19 or training about personal protective equipment required. An interview on 05/24/20 at 12:36 PM, with Dietary Staff B and D, revealed that they had not received any training concerning COVID-19 or training about personal protective equipment required. An interview on 05/25/20 at 2:01 PM, with Dietary Staff E, revealed she was not sure if she had received any training concerning COVID-19 or training about personal protective equipment required. An interview on 05/25/20 at 2:02 PM, with Dietary Staff C, revealed she had not received any training concerning COVID-19 or training about personal protective equipment required. Review of In-Service Training records, revealed one COVID training had been provided to a limited number of staff on 05/13/2020 and 05/14/2020. There were a total of 10 facility staff who attended this in-service. This review revealed LVN A, RN B, Dietary Staff B, C, D, and E, were not provided this training. No other COVID training records were revealed. Review of the COVID Response for Nursing Facilities, version 2.9, dated 05/19/2020, revealed the following: (in part) -Provide adequate staff with training, skills, and competencies for COVID-19 care. -PPE and Infection Control Education and Training - Ensure staff are educated and trained on which PPE they should use, proper procedure for donning (putting on) and doffing (taking off) PPE, and how to determine if the PPE is contaminated or damaged. -NFs must identify whether the following concerns exist and specifically address them through education and training: improper use of PPE o lack of understanding of proper use of each type of PPE -If the NF is following the CDC's or DSHS' guidance for optimizing the supply of PPE, inform staff of the expectations specific to the type of PPE they are using. PPE education and training for staff should include at least the following information: PPE - simple, easy to understand training that includes: - use of PPE in a NF without a known positive case of COVID-19 - use of PPE in a NF with a suspected or positive case of COVID-19 - donning and doffing sequence and procedures - procedures, if any, for optimizing the use of PPE - procedures for determining if the PPE is contaminated or soiled - procedures for disposal of PPE (contaminated or uncontaminated) - Infection Control - simple, easy to understand training that includes: - protocols, policies, and procedures for use during: monitoring for COVID-19 Record review of the staff sign in log, dated 05/25/20, revealed CNA A and CNA B had been working in the facility on this date. Review of the Mass Testing Log, dated 05/22/2020, revealed CNA A and CNA B had not been tested on this date. Review of a list of staff currently working in the facility, dated 05/26/2020, revealed the Administrator was working in the facility on this date. Review of the Mass Testing Log, dated 05/22/2020, revealed the Administrator had not been tested on this date. Review of the sign in log, located at the entrance of the facility, dated 05/27/2020, revealed two hospice personnel were allowed to enter the facility on this date. Review of the Mass Testing Log, dated 05/22/2020, revealed these personnel had not been tested on this date. An interview on 05/26/20 at 10:42 AM with the Administrator, who was present in the facility, revealed she was not tested during the mass testing on 05/22/2020. She stated she had been tested for COVID 19 in Dallas this morning but had not received the results. This interview revealed the Administrator was unable to provide negative COVID-19 testing results for herself, CNA A, CNA B, or the two hospice personnel, who were all identified as being in the facility. (f) An interview on with LVN A, on 05/23/20 at 12:20 pm, revealed 4 residents (including resident ID #s 1 and 3) were housed on Hall D, which was designated as an isolation hall, for residents requiring monitoring for symptoms of COVID-19. Resident ID #1 Review of residents tested for COVID-19, on 05/22/2020, revealed resident ID #1 was not tested on this date. In an observation on 5/22/20 at 7:25 pm resident ID #1 was sitting in a wheelchair, in the small dining area, without a facial mask on, leaving her mouth and nose exposed. An observation on 05/24/20 at 12:30 PM revealed resident ID #1 was not isolated and was seated in the main common area of the facility, near the entrance door, with 4 other residents. Resident ID #3 Review of resident ID #3's Face Sheet, dated 05/22/2020, revealed she was an [AGE] year-old female, admitted to the facility on [DATE], with the following Diagnoses: [REDACTED]. Review of residents tested for COVID-19, on 05/22/2020, revealed resident ID #3 was not tested on this date. An observation on 05/23/2020 at 12:15 pm, revealed resident ID #3, was seated at the Nurses' Station, on a walker. Resident ID #3 was not isolated and was in areas with other facility staff and residents. An interview with resident ID #3, on 05/23/20 at 12:17 pm, revealed she had not been tested on [DATE]. Resident ID #3 stated they did not explain to me that if I was not screened that it would cause so much trouble. Resident ID #5 Review of resident ID #5's Face Sheet, dated 05/22/2020, revealed she was an [AGE] year-old female, admitted to the facility on [DATE]. No diagnoses were noted on this document, due to her being newly admitted . (As a newly admitted resident, Resident #5 should have been in isolation.) An observation on 05/22/2020 at 6:18 pm, revealed resident ID #5 was wandering the halls, without a facial mask on, leaving her mouth and nose exposed. Resident ID #5 was less than 6 feet away from other residents and facility staff. Facility staff did not try to intervene or re-direct resident #5 at any time during this observation. Review of HHSC's Frequently Asked Questions, Nursing Facility, COVID-19 Testing, dated 05/15/2020, revealed the following: (in part) - Residents who refuse testing should be treated as though they are positive and isolated and monitored for 14 days. However, they should not be co-horted with residents with confirmed positive cases. Staff who refuse testing should stop working and self-quarantine at home and self-monitor for 14 days unless they provide proof of a negative PCR test. Review of the COVID Response for Nursing Facilities, version 2.9, dated 05/19/2020, revealed the following: (in part) - Restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If they leave their room, residents should wear a facemask, perform hand hygiene, limit their movement in the facility, and keep a distance of 6 feet between themselves and other residents. - Prevent spread of COVID-19: Actions to take now: Enforce social distancing among residents. Review of the facility's Infection Control Policy, dated 08/18/2017, revealed the following: (in part) Goals: -Identify and correct breaches in infection control practices that may have contributed to the spread of healthcare associated infection; -Prevent the further spread of infection through the initiation of appropriate precautions; -Identify and treat organism that have a high risk of transmission, severity of disease, and/or are difficult to treat. New Disease: When new diseases occur, the facility incorporates the policy the regulations, guidelines, and when possible the suggestions of all federal, state, and regulatory agencies, as the regulations and guidelines are developed and released to the public. Review of the facility's Isolation Policy, dated 04/04/2017, revealed the following: (in part) Transmission based precautions: A. Standard precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. Types of precautions: 1. Airborne precautions: These are utilized for anyone who has documented or suspected to being infected with microorganisms transmitted by airborne droplets nuclei of evaporated droplets containing microbes that remain suspended in the air and can be widely dispersed by air currents with room or space. 2. Respiratory protection: - All individuals must wear approved respiratory protection when entering the room. On 05/22/2020 at 7:40 pm, the facility DON was made aware of an Immediate Jeopardy, the DON stated she would notify the Administrator, who refused to return to the facility, during this visit. The IJ template was provided at this time. The facility's Plan of Removal was submitted on 05/27/2020 and was accepted on 05/29/2020 at 3:35 pm. The Facility's Plan of Removal included the following: Facility Failed to Implement Infection Control Measures 1. On Saturday May 23, 2020, housekeeping staff moved the screening location from the nursing station into the resident common area (19 feet from the nursing station and 4 feet 9 inches from the entrance door). 2. On Friday May 22, 2020 the Administrator hired additional staff to occupy the office 6 feet from the front door from M-F, 8:30 A.M.-5:00 P.M. to screen people entering the facility. She will have a 30-minute lunch break to be coordinated with the nursing staff who will provide screening during this 30-minute period. 3. The facility will provide screening at the location 4 feet 9 inches from the entrance door for all essential visitors, staff, and returning residents. Emergency Medical Personnel will be screened only in non-emergency situations. The screening will include completing the Long-Term Care Facilities Coronavirus Disease 2019 (COVID-19) Symptom Monitoring Log. The facility will actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. Those with symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) will not permitted to enter the facility at any time. 4. On Tuesday, May 26, 2020, the Administrator held a mandatory all-staff in-service discuss the requirements for handwashing, facemasks, screening, and disinfecting surfaces to prevent the spread of infection. 5. During the May 26, 2020 in-service, staff were notified of the requirement to only enter the facility through the front door. Staff were notified that they must remain at the screening location until they have been properly screened before proceeding further into the common area. 6. On Wednesday, May 27, 2020, the Environmental Services Supervisor contacted a lock smith and scheduled to re-key 5 exit doors (Main entrance, and A-D Hall Exit doors) on Tuesday, June 2, 2020. These doors will always remain locked from the outside. Entry will only be aided by inside staff members charged with screening. The Administrator notified staff that missed the in-service of the

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) requirements for entry only at the front door. Staff missing the in-service will receive corrective action for missing the in-service and will be require to provide proof of infection training at their own expense before returning to work. 7. On Tuesday, June 2, 2020 a locksmith will determine what must done to repair/rekey the Service area door near the Kitchen/Laundry room. This door will also be locked to prevent entry from the outside and thus isolate entry at the point of COVID-19 screening. Failed to wear face masks in a manner to protect themselves or others from the [MEDICAL CONDITION] 1. On Tuesday, May 26, 2020, the Administrator notified all staff members that missed the May 26, 2020, infection control in-service that they must only enter the facility through the front door, wearing a well fitted mask, and be screened for COVID-19 prior to passing the screening station into the facility. These staff members were notified that they must complete infection control training prior to returning to work. Facility allowed staff to remain in the facility who were not tested through mass testing and did not have proof of a negative test result. 1. Pursuant to Frequently Asked Questions Nursing Facility COVID-19 Testing May 15, 2020 (#29) which states: All staff members must have a test as part of this initiative. If a staff member misses the testing at the facility, they should have their test conducted at another location prior to returning to work. The Administrator notified four staff members that did not receive testing that they must provide proof of being tested prior to returning to the facility. All four members are scheduled to be tested Wednesday, May 27, 2020. Residents who were not tested for COVID-19 during mass tests were not isolated and allowed in common areas of the facility. 1. The two residents that were not tested for COVID-19 have commenced isolation in a separate area of the facility. Dietary staff were able to enter the facility through a kitchen door without screening for symptoms of COVID-19. 1. On Tuesday, May 26, 2020, the Administrator notified the four Dietary staff members that missed the in-service that they must only enter the facility through the front door, wearing a well fitted mask, and be screened for COVID-19 prior to passing the screening station into the facility. These staff members were notified that they must complete infection control training prior to returning to work. 2. Two dietary staff members were identified that work on Friday, May 22, 2020, but were not screened. The records show that these employees had been screened on prior days. These two employees will receive written corrective action for failure to follow the screening procedures. The facility Administrator and Director of Nursing failed to provide sufficient training and oversight to staff during the COVID-19 pandemic. 1. On Tuesday, May 26, 2020, the Administrator held another mandatory all-staff in-service to discuss infection control (Previously presented on March 24, 2020, and ongoing weekly). The Administrator provided additional infection control training for COVID-19. The in-service discussed the requirements for handwashing, facemasks, screening, and disinfecting surfaces to prevent the spread of infection. During the in-service one employee was suspended 3 days for failure to wear a mask in a manner to protect herself and other from the spread of infection. The employee had previously received written corrective action for the same offense. Monitoring of the facility conducted by the surveyor to ensure the residents safety: Review of the attendance sheets for in-services, provided by the Administrator, on 05/28/2020, revealed she had provided in-service training to the facility staff. This review revealed documentation reflecting infection control and COVID-19 training was obtained by staff, on their own, if they were not present for the training provided by the Administrator. An observation on 05/29/2020 at 1:30 pm, revealed immediate screening of surveyor upon entering the facility, and all staff were observed wearing facemasks appropriately. An interview with Dietary Staff B, on 05/29/2020 at 3:05 pm, revealed everyone had been informed that only the front entrance was to be used to enter into the facility and that the other doors were now locked from the outside. An interview with RN A on 05/29/2020 at 2:00 pm revealed that screenings are being performed on everyone who enters the building and those who do enter the facility are wearing appropriately fitting masks at all times. The Administrator was notified on 05/29/2020 that the IJ was lowered at 3:35 p.m. While the IJ was lowered on 05/29/2020, the facility remained out of compliance at a severity level of potential for more than minimal harm and a scope of widespread, due to the facility's need to complete in-service training, monitor the implementation of their plan of removal and evaluate the effectiveness of their plan of removal.