STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676470	A. BUILDING _____ B. WING _____	**09/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOUSTON HEIGHTS HEALTHCARE CENTRE	**6534 STUEBNER AIRLINE ROAD HOUSTON, TX 77091**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent injuries for 1 of 4 residents (Resident #1) and 1 of 1 secure units reviewed for accidents/supervision. -The facility failed to ensure staff did not leave the quarantine unit unsupervised and were unaware that Resident #1 had fallen and was on the floor in his room. -The facility failed to have a staff member in the secure unit at all times. These failures could place all residents who require assistance from staff and placed them at risk of delayed assistance and injury. Findings include: Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS dated [DATE] revealed a BIMS of 07 out of 15 indicating the resident had moderately impaired cognition. He required supervision for bed mobility, transfer, locomotion on room, eating and toilet use. He required one-person assistance with dressing and personal hygiene. He used a wheelchair for mobility. He was assessed as having had one fall with major injury since admission. Record review of Resident #1's care plan initiated on 7/13/20 revealed the following: Focus: Resident has legally blind diagnosis; risk for falls/inquiries; risk for unmet needs; risk for social isolation. Goal: Resident will not have increased potential for falls/inquires; social isolation; unmet needs without intervention times 30 days. Interventions: Provide barrier free environment; enhance lighting using artificial and natural lighting; encourage and remind resident to call for assistance; support visual access when care is not in progress; keep personal items within reach; call light within reach; observe resident for increased need for social support; social work and activity visits for social stimulation and reduce potential for social isolation/boredom; encouraging resident communication for needs/wants. Focus: Resident has an ADL self-care performance deficit related to confusion, impaired balance, impaired coordination, stroke. Goal: Resident will participate to the best of their ability and maintain current level of functioning with activities of daily living through the next review period. Interventions: Encourage independence, praise when attempts are made. Provide shower, shave, oral care, hair care, and nail per schedule and when needed. Resident requires staff x 1 to turn and reposition for safety. The resident requires staff x 1 to use toilet. Resident participates in toileting process. Resident requires staff x 1 with bathing for safety. Resident uses a walker and wheelchair for mobility. Resident is independent in transfers. The resident can bathe self once they are set up with SBA of staff x 1. Resident requires staff x 1 for dressing upper and lower extremities. Resident requires limited to extensive assistance for safety. Resident requires staff x 1 to choose simple comfortable clothing and for ability to dress self for safety. The resident requires staff x 1 to set up or assist with oral care. Encourage resident to use bell to call for assistance before attempting any ADL's that resident cannot do independently. Observation and interview on 9/11/20 at 12:25 pm revealed the quarantine unit was unattended. The quarantine unit had 6 rooms. There were 3 vacant rooms. There were 3 residents (Resident #1, #2, and #3) in their rooms. Resident #1 was asleep; he had his lunch that had not been touched uncovered on a Styrofoam plate that was placed against the wall by his bedside. Resident #2 was sitting up at 45-degree angle about to have lunch; and Resident #3 was sitting up at 90-degree angle eating lunch while watching TV in bed. Resident #3 asked this Surveyor to adjust his bed to a 90-degree angle, so he could eat his lunch. This Surveyor prompted the resident (outside his door) to use his call light. The call light was tucked underneath the resident. The resident could not reach his call light. This Surveyor told resident she would get help. Observation on 9/11/20 at 12:32 pm revealed CNA A entering the quarantine unit. She was wearing a surgical mask. In an interview on 9/11/20 at 12:35 am with CNA A, she said she left the unit unattended to go to the restroom. She said she was not supposed to leave her unit unattended. She said she was supposed to call the charge nurse to come relieve her. She said she was supposed to call the charge nurse when Resident #1 refused to eat. She said he had been eating good, but not today. Observation on 9/12/20 at 12:23 pm revealed the quarantine unit was left unsupervised. Resident #1 was not in his bed. His bed was in the lowest position. Resident #2 was asleep covered in his blanket. Resident #3 was sleeping covered in his blanket. Observation and interview on 9/12/20 at 12:25 pm revealed CNA B sitting in the dining area outside of the quarantine unit asleep with her head bowed down. Her surgical mask laid on her chin leaving her nose and mouth exposed. After a few minutes she woke up startled. She said she was waiting on the resident's meal trays. She said they usually brought them over about 11:30 am but for some reason they were late that day. She said she had been waiting in the dining room since 11:30 am. She said she knew she was not supposed to leave her unit unattended. She said the residents could choke, fall or be seriously injured if left unattended. Observation on 9/12/20 at 12:27 pm accompanied by CNA B revealed Resident #1 nowhere to be found. The resident was not in his bed or restroom. His bed was in the lowest position. CNA B said Resident #1 should have been in his room. She looked for the resident from the door and she did not see him either. She said, Maybe he went to P.T. or O.T. This Surveyor went to get the Administrator. The Administrator said Resident #1 should have been in his room. She accompanied this Surveyor back to the quarantine area. She washed her hands, donned gown, N95, face shield and gloves and entered Resident #1's room. She said she did not see him in the room. She washed her hands and doffed gown and gloves. She left the quarantine unit to get the charge nurse. As this Surveyor passed Resident #1's door movement on the floor was noticed and it was Resident #1. The Surveyor summoned the CNA B to make her aware. Observation and interview on 9/12/20 at 12:28 pm accompanied by the Administrator revealed Resident #1 was not in his bed. His bed was in the lowest position. The Administrator washed her hands, donned PPE (gown, N95, face shield and gloves). She entered Resident #1's room and called out his name. There was no response. She looked around the room, checked the restroom and she did not see Resident #1. She said, maybe he is at therapy .I know he is getting O.T. or P.T. She said, let me go see if I can find him. She doffed PPE (gown, face shield and gloves) and washed her hands. She left to go search for Resident #1. Observation and interview on 9/12/20 at 12:31 pm revealed Resident #1 was on the floor laying on the fall mat that was placed to his right side. His bed sheet was tangled. This Surveyor called out to Resident #1 from his door to ask him if he was okay. He mumbled words, but he could not be understood. This Surveyor asked Resident #1 if he knew what happened and he said no. Observation and interview on 9/12/20 at 12:32 pm revealed the Administrator returning to the quarantine unit with the RN. This Surveyor brought to their attention that Resident #1 was in his room on the floor. The Administrator, accompanied by the RN, witnessed Resident #1 on the floor. The RN left and returned minutes later to assist with getting Resident #1 off the floor. He required two-person assist to get him back on his bed. The Administrator said staff knew better. She said CNA B knew she was not supposed to leave the unit unattended. She said they were supposed to call the charge nurse for breaks and lunch. In an interview on 9/12/20 at 12:35 pm with RN, he said CNA's could leave the quarantine unit only when they called him. He said, (for example, go to the restroom, breaks and lunch). He said staff should never leave the unit unattended because of resident safety. He said what could happen is like what happened with finding Resident #1 on the floor. He said charge nurses were responsible for monitoring CNA's to ensure they were at their

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) designated assignments. He said Resident #1 would lay on the floor by himself. He said, if you noticed, he was on the floor on his right side where his fall mat was placed. He said risk of falls could lead to injuries or worst-case scenario hematoma. He said he assessed Resident #1 and he had no complaints of pain. He said he assessed his range of motion and Resident #1 was okay. He said he was responsible for Hallway 100 and the quarantine unit. In an interview on 9/13/20 at 5:30 pm with DON, he said he disciplined CNA B for leaving the quarantine unit unattended, not wearing proper PPE and hand hygiene. He said there was no reason for staff to leave the unit unattended because they could use the restrooms in the vacant rooms. He said staff were not supposed to leave their units unattended. He said he monitored the quarantine unit frequently, every 1 to 1 hours. In a follow-up interview on 9/13/20 at 7:00 pm with CNA B, she said she was disciplined for leaving the quarantine unit unattended. She said, I know now not to leave the quarantine unit unattended. Secure Unit Observation and interview on 09/11/20 at 11:30 am, revealed Activity Director/CNA coming out the secure unit and going down the hall way. Surveyor walked up to the glass doors looking into the secure unit and did not see any staff in there. One resident was observed ambulating independently on the hall way. LVN C was observed sitting at the nurse's station outside of the secure unit. Interview with LVN C at this time, she said she had only been there for 5 days and works full time. When asked if any staff were in the secure unit at this time, she said there was not. When asked where the staff were, she said the CNA just stepped out and will be right back. When asked if she had received any training about secure unit she said she had and that she was sitting at the nurses station and watching the unit so thought it was ok for CNA to leave. Observation of the secure unit on 09/11/20 at 11:35 am, revealed no staff inside the unit. Interview with Activity Director/CNA on 09/11/20 at 11:40 am, outside the unit she said she was the Activity Director and also a certified CNA. She said she was working as a CNA and helped out wherever needed. She said she was the memory care aide today (9/11/20). She said she had to use the restroom and that was why she stepped out. She said she told LVN C when she came out of the secure unit. She said she was allowed to leave the unit to use the restroom as long as she let other staff know. Interview with Administrator and DON on 09/11/20 at 12:39 pm, the Administrator said LVN C was supposed to be inside the secure unit when the CNA left. She said maybe the LVN did not know because this was her first week at the facility. She agreed that the secure unit should not be left unattended. The Administrator said, If they need to step out, they need to notify other staff. She said she was going to initiate in-services now. Record review of LVN C's personnel file did not reveal any documentation of her having any in service on secure unit. Interview with Administrator on 09/11/20 at 1:08 pm, when asked about their policy for secure unit she said she spoke with the clinical director and they don't really have a policy for the secure unit regarding staffing because they should be staffing accordingly but that that a staff member should be inside the secure unit at all times. Policies requested for supervision on 9/12/20 at 1:30 pm and on 9/17/20 at 9:45 am. The facility did not provide their policy prior to exit.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with established food preparation practices and safety techniques for 1 of 1 kitchens reviewed for food preparation practices in that: -Cook A was not wearing a beard guard in the kitchen. This failure placed all residents who received meals from the kitchen at risk for food borne illness and cross-contamination. Findings include: Observation and interview on 9/12/20 at 1:25 pm revealed Cook A washing dishes in the facility's kitchen. He was not wearing a beard guard. He should have been wearing a beard guard. He said he had been working at the facility for two weeks. He said he did not know he was supposed to wear a beard guard. He said the facility did not have beard guards. Interview on 9/12/20 at 2:15 pm with Administrator, she said Cook A knew he was supposed to wear a beard guard. She said, He knows better. Interview on 9/13/20 at 5:15 pm with the Dietary Manager, she said males working in the kitchen were required to wear hair and beard restraints to cover their hair. She said because of the risk that hair could fall into the food causing cross-contamination. She said she in-serviced staff on hair restraints about 4 to 5 months ago. She said the new guy (referring to Cook A) should have known beard guards could be found in the same place hair nets were located. She said, that's bull that he didn't know. She said she would in-service Cook A. Facility's policy on wearing beard guards was requested on 9/12/20 at 2:16 pm and on 9/13/20 at 5:17 pm. The facility's policy was not provided prior to exit.
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 Control Program designed to prevent, recognize, and control the onset and spread of infection to the extent possible for 3 of 3 residents (#1, #2 and #3) reviewed for infection control in that: -CNA A did not sanitize or wash her hands between resident encounters for Resident's #1, #2 and #3. -CNA's A and B did not wear proper PPE while providing care to resident's #1, #2 and #3 in the quarantine unit. -LVN A did not wear proper PPE while providing care to Resident #1. -The facility did not have signage posted on the quarantine unit entry doors. -The facility failed to implement their policy to ensure staff, who were providing care to the quarantined residents wore appropriate PPE of N95 respirator, gown, gloves, and goggles or face shield when caring for quarantined residents. An Immediate Jeopardy (IJ) was identified on 9/11/20. While the IJ was removed on 9/13/20 the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate threat and a pattern of isolated while they continued to monitor their plan of removal. These failures could affect all residents on the quarantine unit and place them at risk of contracting an infectious disease. Findings include: Record review of the Centers for Disease Control website at CDC.gov on 6/11/20 revealed, .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown. Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. . Resident #1 Record review of Resident #1's face sheet revealed a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS of 07 out of 15 indicating the resident had moderately impaired cognition. He required supervision for bed mobility, transfer, locomotion in room, eating, and toilet use. He required one-person assistance with dressing and personal hygiene. Record review of Resident #1's care plan initiated on 5/21/20 revealed the following: Focus: Resident #1 is potential risk for exposure to infectious disease: COVID 19. Goal: Resident #1 will have minimal exposure to COVID 19 during the review period. Interventions: 14-day observation related to new admission. Follow facility protocol for COVID -19 screening and precautions; and observe for signs/symptoms of COVID 19; document and promptly report signs/symptoms: fever, new/worsening cough, sore throat, shortness of breath. Resident #2 Record review of Resident #2's face sheet revealed a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #2's annual MDS assessment dated [DATE] revealed a BIMS of 07 out of 15 indicating the resident had moderately impaired cognition. He was assessed as requiring supervision with setup help for bed mobility. Transfers, walking in the room, and walking in the corridor were coed as a 6/6, which was not on the coding key for the document. He was coded as a 5/1 for dressing, which was also not on the coding key for the document. He was assessed as needing limited set up assistance for eating. He required supervision for toileting. He was not coded for Section K: swallowing disorder. Section O: Special treatments, procedures, and programs revealed the resident was coded for M. Isolation or quarantine for active infectious disease. Record review of Resident #2's care plan initiated on 9/2/20 revealed the following: Focus: Resident #2 is potential risk for COVID 19 pandemic infection. Goal: Resident #2 will not have increased potential for COVID 19 infection without intervention throughout the review period. Interventions: Educate resident and staff re: CDC guidelines for prevention of COVID 19 transmission; frequent handwashing and sanitizer use; masking during care; social admission; documentation of any signs/symptoms of concerns. Resident #3 Record review of Resident #3's face sheet revealed a [AGE] year-old male who was initially admitted on [DATE] and readmitted on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #3's care plan initiated on 4/9/20 and revised on 4/13/20 revealed the following: Focus: Resident #2 is

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) at risk for exposure to infectious disease: COVID 19. Goal: Resident #2 will have minimal exposure to COVID 19 during the review period. Intervention: Educate staff, client, family and visitors of COVID-19 signs/symptoms as well as precautions. Follow facility protocol for COVID -19 screening and precautions; and observe for signs/symptoms of COVID 19; document and promptly report signs/symptoms: fever, new/worsening cough, sore throat, shortness of breath. Observation on 9/11/20 at 10:44 am revealed the quarantine unit had a sign posted on the entry door that said, staff/employees only. There was no signage posted indicating the unit was a quarantined unit. The unit had one entry. The back of the unit had sealed barrier with heavy plastic sheeting that extended from the ceiling to the floor and walls. No one was able to enter through the sealed barrier. Observation on 9/11/20 at 10:45 am revealed Resident #1 in bed with his eyes closed. He was tucked in under his blanket. His bed was in the lowest position. There was a fall mat on the right side of the bed. There was a shake container on his rolling table. There was a box about 2 feet in front of Resident #1's bed, instead of at the exit to the room, that had a red biohazard waste bag. A second box with a yellow bag was adjacent to the first box. Both boxes were uncovered. In an interview on 9/11/20 at 10:46 am with CNA A, she said she had worked for the facility for 1 year and 4 months. She said she was designated to work the quarantine unit. She said the yellow bag in the box in Resident #1's room was for laundry. She said the red bag was to doff PPE. This Surveyor asked CNA A where the biohazard bag should be located. She said she did not know. Observation and interview on 9/11/20 at 10:47 am with CNA A revealed CNA A was wearing only a surgical mask. She was not wearing a gown, N95 respirator, goggles/face shield, or gloves. CNA A went into quarantine resident rooms (202, 203 and 205), and was within 6ft of the residents. PPE was located outside each resident's room. CNA A entered Resident #2's room to adjust his bed and clip his call light to his gown. She was not wearing gloves. She left Resident #2's room and walked into Resident #1's room without washing her hands or using hand sanitizer or donning gloves. She stooped down by Resident #2's bed to ask him if he wanted to eat. She was within 1 foot of the resident. Resident #2 declined, and she tucked Resident #2 in his bed with his blanket and left the room. She proceeded to Resident #3's room without washing her hands or hand sanitizing or donning gloves. She was observed within 1 foot from Resident #3 while asking him if he was okay. CNA A said she was told she did not have to wear a gown, face shield, or N95 for residents in quarantine because the residents tested negative prior to discharge from the hospital. She said residents that had one overnight stay at the hospital had to be quarantined when they returned from the hospital because they were told there was the possibility residents could contract [MEDICAL CONDITION] between the date of discharge and the date of arrival to the facility. This Surveyor asked her if readmits status was considered unknown status. She said yes. When asked to confirm, the regarding the residents in quarantine, whether the staff knew if the residents in quarantine were positive or negative, she said, Yes, we don't know, so I should be wearing full PPE. She said full PPE would include gown, N95, goggles or face shield and gloves. She said she made a mistake because she knew she was supposed to wash her hands between residents. She said she was supposed to wash her hands before and after resident care. She said only one person was allowed in the quarantine unit. She said Resident #1 required one-person assistance with feeding, repositioning, turning, bathing, and personal hygiene. She said he got a bed bath every other day. Observation and interview on 9/11/20 at 12:32 pm revealed CNA A entering the quarantine unit. She was wearing a surgical mask. She said she had been in the restroom. This Surveyor told her Resident #2 required her assistance. She entered Resident #2's quarantine room wearing only a surgical mask. She did not wash her hands or use hand sanitizer. She did not wear a gown, N95, goggles or face shield or gloves. She tried to adjust Resident #2's bed, but the mechanical frame was in disrepair. She was observed telling Resident #2, That's as far as it goes up. She placed a pillow to help increase the Resident's position, so he could eat without aspirating. She left Resident #2's room and entered Resident #1's room. She did not wash her hands. She was wearing a surgical mask. She was not wearing a gown, N95, goggles or face shield, or gloves. She looked at the lunch tray, picked up the meal ticket, and bent down to the resident's level (bed in lowest position) to ask the resident if he wanted to eat. She asked twice, and he responded no twice. She asked him if he was cold and he said yes. She tucked him in with his blanket. She left Resident #1's room and entered Resident #3's room. She did not wash her hands or use hand sanitizer. She only wore a surgical mask. She was not wearing a gown, N95, goggles or face shield or gloves. In an interview on 9/11/20 at 12:35 am with CNA A, she said she was supposed to wash her hands after doffing gloves and before and after making contact with residents. She said she made a mistake by not washing her hands. She said she was not wearing full PPE (gown, N95, goggles or face shield) because she was told she did not need to wear PPE in the quarantine unit. Observation on 9/11/20 at 12:39 am revealed the quarantine unit had a sign posted on the entry door that said, staff/employees only. There was no signage posted indicating the unit was a quarantine unit. The unit had one entry. The back of the unit had a sealed barrier with heavy plastic sheeting that extended from the ceiling to the floor and walls. No one was able to enter through the sealed barrier. Observation and interview on 9/11/20 at 12:40 pm with LVN A revealed her entering Resident #1's room wearing only a surgical mask. She washed her hands. She grabbed gloves from inside the resident's room and put them on. She did not don a gown, N95, goggles or face shield. She picked up the resident's meal ticket. She went to Resident #1's bedside, stooped down to Resident #1's bed to ask him if he wanted to eat. He said no. She was within foot in distance from the resident. She asked him if he would like a shake and he said yes. She prepared the shake, doffed gloves, washed her hands, and left the room. She said she did not know the difference between isolation and quarantine. After guidance, she said unknown status would prompt her to wear full PPE (gown, N95, goggles or face shield and gloves). She said she was told by another nurse that PPE was required only for residents with positive results for COVID. She said she was responsible for the quarantine unit. She said she was also responsible and worked in the non-quarantine rooms 101-110 and 120-130. She said she started working at the facility this past Thursday, 9/3/20 and she had not received any training. LVN A headed back to work at non-quarantined units. Observation on 9/11/20 at 12: 50 pm revealed LVN A walking the hallways of unit 100. She was wearing a surgical mask. Observation and interview on 9/11/20 at 12:55 pm accompanied by LVN A revealed clean linen uncovered and left on shower cart, one soiled flat bed sheet and one 15 ounce bottle of tropical coconut conditioner left open in the community shower room located behind the first nurse's station by Unit 100. LVN A said the clean linen and soiled bed sheet should not have been left out. She said the clean linen belonged in the clean linen closet. She said the soiled bed sheet should have been placed in the soiled linen bin. She said it was important to keep clean linens and soiled linens in their appropriate place to prevent infection and cross-contamination. Interview on 9/11/20 at 1:40 pm with Administrator and ADON, the ADON said she had just started on 8/31/20. She said there were 4 residents in quarantine. She said Resident #1, #2 and #3 were re-admits from the hospital. She said Resident #4 was in quarantine because he was sent to the hospital for blood [MEDICAL CONDITION] when he was at [MEDICAL TREATMENT]. She said Resident #4 was getting ready to be moved back to his room because his quarantine days were completed. She said residents got negative tests from the hospital. She said the facility would retest residents when they were close to the 9th day, so they could come out of quarantine on the 10th day. She said residents were being monitored for COVID at every shift and it was documented on their MAR's. She said isolation meant residents were positive. She said quarantine meant monitoring symptoms or waiting on pending test results. She said when residents arrived, the facility had to have the test results from the hospital. She said if positive, the facility would not retest. She said if negative and the facility received the negative results from the hospital, the facility would not retest readmits. She said, even if residents tested negative at the hospital two days ago, they would still have to be monitored for symptoms upon readmission. The Administrator said, sometimes symptoms don't show up for 2 to 5 days. The Administrator said staff still had to wear PPE when making contact with residents in quarantine, even if readmits tested negative at the hospital prior to discharge. She said staff was supposed to be wearing gowns, N95's, goggles or face shields and gloves. The ADON said the charge nurse had oversight to ensure staff were wearing the appropriate PPE. Interview on 09/11/20 at 1:50 pm with Administrator and DON, the Administrator said that staff were to wear N95, gown, and gloves when caring for quarantine residents. She said face shields were only used if residents were positive for COVID. The Administrator said the charge nurse was supposed to monitor the quarantine unit to ensure staff was wearing appropriate PPE. The DON said he did not know if staff was supposed to wear full PPE (gown, N95, goggles or face shields and gloves) because he was new to this facility. He pointed at the Administrator and said, what she said. The Administrator said, you see all this PPE, so I don't know why they are not using it. She said she was responsible for tracking the burn rate, so she always knew how much PPE the facility had on hand. The DON said residents had to have orders for COVID testing. He said the facility did not have dedicated staff for the quarantine unit. He said all facilities were having the same staffing issues. Observation and record review on 9/11/20 at 1:55 pm of the Administrator's office revealed the facility had an abundance of PPE. Record review of the facility's tracking spreadsheet for PPE inventory on hand, not dated revealed the facility had the following PPE supplies on hand: 2,835 N95's, 990 gowns, 5150 face masks, 1000 face shields, 90 safety glasses, 1,512 KN95's, 8,150 small gloves, 5,000 medium gloves, 6,000 large gloves and 50 XL gloves.

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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) Record review of the facility's COVID policy, titled: Coronavirus Emergency Pandemic Policy Addendum dated 8/22/20 read in part . The center will be utilized - N95 (if possible)/KN95, eye protection, gloves, and isolation gown. Employees will be assigned to work the hall with probable/presumed or confirmed only. Minimize all employees from working across units or halls. Staff and residents perform appropriate hand hygiene before and after each activity. A face mask for source control does not replace the need to wear an N95 or higher-level respirator (or other PPE) when indicated, including when caring for patients with probable or confirmed COVID 19 . Record review of the facility's infection control policy titled: Infection Control - Standard Precautions dated 3/1/20 read in part . 1. Hand hygiene a. hand hygiene refers to handwashing with soap or the use of alcohol-based hand rub. B. hand hygiene is performed with alcohol-based hand rub (1) before and after contact with the resident. (3) after contact with items in the resident's room; and after removing PPE. After gloves are removed, wash hands immediately to avoid transfer of microorganisms to other residents or environments . These failures resulted in an Immediate Jeopardy (IJ). The facility Administrator, DON and ADON were notified of the IJ on 9/11/20 at 5:45 pm and a plan of removal (POR) was requested at that time. The IJ template was left with the Administrator. The POR was accepted on 9/11/2020 at 10:23 pm after one revision. The POR read in part: .Plan of Removal for Immediate Jeopardy: Identify responsible staff/what action taken: All staff working the quarantine hall that provide essential care. All staff are being in serviced on the required PPE (gown, N95, eye protection and gloves) to be worn on the quarantine hall. Who/which staff will monitor this and how often? Who will conduct the training and verify return demonstration? DON/designee will monitor the appropriate process for PPE is being followed on the quarantine hall. The monitoring will be completed daily by the DON/designee. The DON will initiate the in-service training 9/11/20. The facility will provide separate spaces to don (put on) and doff (take off) PPE when possible. Will post PPE required for quarantine on door/barrier going onto the quarantine hall. All staff are being in-service on the hand hygiene and went to wash hands/use hand sanitizer. This in-service was started will be initiated on 9/11/20 by the DON/designee. Who will verify competency to return demonstration? DON/designee will validate competency with handwashing via return demonstration. Facility will have designated staff for the quarantine hall unless required on another call hard to maintain adequate staffing . In service conducted: in-service was conducted by DON and Administrator on 9/11/20. The in-service is on infection control. The details of the in-service include: All staff are being in-serviced on the PPE required for quarantine residence. The following procedure will be followed: staff will don an N95 and eye protection will be worn on the quarantine hall throughout the shift, gown and gloves will be changed with each resident encounter. Hand hygiene will be performed prior to donning gown and exiting resident room. The in-service was attended by licensed nurses which include registered nurse license vocational nurse certified nursing assistance, certified medication aid, and licensed therapist which include physical therapist, occupational therapist and speech therapist, housekeeping, maintenance, activities. For licensed staff we are unavailable for training on this date, they will not be allowed to return to work until training is complete. This in-service will be started on 9/11/20. Monitoring: The Administrator/DON/ADON will be responsible for monitoring the implementation and effectiveness of in-service on 9/11/20. DON/designee will mentor that the appropriate process for PPE is being followed for quarantine hall. This monitoring will be completed daily by the DON/designee. The clinical nurse consultant will follow up. Administrator/DON/designee will monitor to ensure staff working the quarantine hall are [MEDICATION NAME] hand hygiene. Staff schedule will be monitored to ensure designated staff assigned to quarantine hall . Following acceptance of the facility's Plan of Removal, the facility was monitored from 9/12/20 to 9/13/20. Observation on 9/12/20 at 12:21 pm revealed the quarantine unit had a sign posted on the entry door that said, staff/employees only. The unit had one entry. The back of the unit had plastic sheeting that extended from the ceiling to the floor and walls. The signage provided written and visual instructions for donning and doffing PPE (gown, mask or respirator, goggles or face shield and gloves). Observation and interview on 9/12/20 at 12:25 pm revealed CNA B sitting in the dining area outside of the quarantine unit asleep with her head bowed down. Her surgical mask laid on her chin leaving her nose and mouth exposed. After a few minutes she woke up startled. She said she had been wearing said surgical mask all morning. She said she should have been wearing her N95 mask while working in the quarantine unit. She said she had just been trained on 9/11/20 for wearing proper PPE in the quarantine unit. She could not explain why she was not wearing an N95. She said she made a mistake. She said she knew the facility was amid an IJ because the DON had explained it in the in-service training she had yesterday. She said she felt very badly that she did not follow protocol. In an interview on 9/12/20 at 12:50 pm with Administrator, she said she in-serviced CNA's this morning. She said she had them do a return demonstration for donning and doffing PPE (gowns, N95, goggles or face shield and gloves). She said she in-serviced staff for proper hand hygiene as well. In an interview on 9/12/20 at 12:55 pm with DON, he said he was going to in-service CNA B again same day. He said she knew better. He said CNA B had just been in-serviced on proper PPE (gowns, N95, goggles or face shield and gloves). He said he made her do a return demonstration. He said, I just don't understand. In an interview on 9/12/20 at 1:05 pm with CNA F, she said she was trained to don and doff PPE. She said she was supposed to put gown, N95 mask, goggles and gloves on when entering resident's rooms in the quarantine unit. She said she was supposed to wash her hands before and after resident care. She said, preferably wash hands. She said she was supposed to wash hands and don new gloves when changing tasks while providing resident care. She said she was supposed to wash and scrub her hands for at least 20 seconds. She said the DON made her do a return demonstration of donning and doffing PPE and proper hand washing. In an interview on 9/12/20 at 1:15 pm with CNA G, he said the Administrator in-serviced him for donning and doffing PPE. He said she made him do a return demonstration. He said he was supposed to put gown first, N95, goggles and gloves. He said the gloves had to be cuffed over the gown. He said when doffing, he was supposed to remove gloves, goggles, gown and then mask. He said he was supposed to throw them in the red biohazard bag prior to leaving resident's rooms. He said he was supposed to wash his hands for at least 20 seconds before and after donning PPE. Observation and interview on 9/13/20 at 4:00 p.m. with Activity Director revealed her sitting in the quarantine unit's hallway wearing an N95. She said she just needed to wear an N95 outside of resident's rooms. She said she was in-serviced on 9/11/20 by the DON and Administrator for donning and doffing PPE and proper hand washing. She said she was supposed to wash her hands prior to entering resident's rooms. She said she was supposed to don PPE (gown, N95, face shield and gloves). She said before leaving the room, she was supposed to doff gown, face shield and gloves. She said she was supposed to throw the gown and gloves in the red biohazard bag and sanitize the face shield after each use and place it in a plastic bag. She said she was supposed to wash her hands prior to leaving resident's rooms. Observation and interview on 9/13/20 at 5:50 pm with Cook B revealed him knocking on the quarantine unit's entry door. He did not go into the unit. He was wearing a hair and beard restraint. He said his dietary manager trained him and told him he was not supposed to enter the quarantine unit. He said she told him to knock and have the staff roll the cart into the quarantine unit when he delivered resident's meal trays. Observation and interview on 9/13/20 at 5:51 pm with Activity Director revealed meals were served on Styrofoam plates and plastic utensils were provided to the residents in the quarantine unit. She said all meals delivered to the quarantine unit were served on Styrofoam plates along with plastic utensils. Observation on 9/13/20 at 5:52 pm revealed Activity Director washing her hands. She turned the faucet on, grabbed soap, scrubbed hands for 20 seconds, rinsed, dried hands with paper towel and turned off the faucet with paper towel. She donned gown. She was already wearing N95 mask. She put her face shield on and donned gloves. She entered Resident #3's room to deliver and set up dinner tray. He was watching TV covered and tucked in his blanket. She set the resident's tray on his rolling table. She doffed her gown, removed face shield and gloves. She threw gown and gloves in the red biohazard bag by the resident's door. She washed her hands prior to leaving the resident's room. She sanitized her face shield and place it in a plastic bag. She washed her hands again. She washed them properly. Observation and interview on 9/13/20 at 5:59 pm revealed Activity Director properly washing her hands to encounter Resident #2. She She donned a gown. She was already wearing N95 mask. She put on her face shield and gloves. She said Resident #2 ate independently. She rang Resident #2 door bell. She entered Resident #2's room to deliver and set up dinner tray on his rolling table. She raised Resident #2's bed upright. Resident #2 asked her to raise the bed higher. The Activity Director attempted to raise the bed higher but, the bed would only go to about a 45-degree angle. She told Resident #2 that the bed would not go any higher and she would report it to maintenance, so they could fix it. She used pillows to help Resident #2 sit up to a 90-degree angle, so he could eat with aspirating. She doffed gown, removed face shield and gloves. She threw gown and gloves in the red biohazard bag by the resident's door. She washed her hands prior to leaving the resident's room. She sanitized her face shield and placed it in a plastic bag. She washed her hands again. She washed her hands properly. Observation and interview on 9/13/20 at 6:05 pm revealed Activity Director properly washing her hands to encounter Resident #1. She donned a gown. She was already wearing N95 mask. She put on her face shield and gloves. She said Resident #1 required one-person assistance with eating. She assisted the resident. She doffed gown, removed face shield and gloves. She threw gown and

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	676470	A. BUILDING _____ B. WING _____	09/17/2020

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 4) gloves in the red biohazard bag by the resident's door. She washed her hands prior to leaving the resident's room. She sanitized her face shield and placed it in a plastic bag. She washed her hands again. She washed her hands properly. She said the DON was monitoring the quarantine unit about every hour to one and a half hours throughout the day. Observation on 9/13/20 at 6:15 revealed LVN B enter the quarantine unit. She was already wearing an N95 mask. She washed her hands. She turned the faucet on, grabbed soap, scrubbed hands for 20 seconds, rinsed, dried hands with paper towel and turned off the faucet with paper towel. She donned a gown. She put on her face shield and gloves. She entered Resident #1's room accompanied by the Activity Director. The Activity Director washed her hands to accompany LVN B. She turned the faucet on, grabbed soap, scrubbed hands for 20 seconds, rinsed, dried hands with paper towel and turned off the faucet with paper towel. She donned a gown. She was already wearing N95 mask. She put on her face shield and gloves. LVN B asked Resident #1 if he wanted to eat. He declined twice. She offered him pudding and he agreed to eat pudding. LVN B fed him the pudding. He ate about three quarters of the serving. The Activity Director was on the opposite side of the bed across from LVN B. In-between LVN B feeding Resident #1 pudding, the Activity Director was encouraging him to drink the shake. Resident #1 finished the shake with a lot of prompting and encouragement. LVN B, doffed gown, face shield and gloves. She threw gown and gloves in the red biohazard bag. She sanitized her face shield. LVN B washed her hands prior to exiting Resident #1's room. The Activity Director waited her turn maintaining social distancing. She doffed gown, face shield and gloves. She threw gown and gloves in the red biohazard bag. She washed her hands prior to exiting Resident #1's room. She sanitized her face shield and placed it in a plastic bag. She washed her hands again. In a follow-up interview on 9/13/20 at 7:00 pm with CNA B, she said the DON re-trained her on the same day she made the mistake to not wear proper PPE and for forgetting to wash her hands before she donned gloves to encounter residents in quarantine. She said she was required to do a return demonstration so that she could demonstrate competency. She said she knew now that she was supposed to wash her hands, don gown, N95 mask, face shield and gloves). She said the gloves were supposed to be cuffed over the gown. She said after providing care, she was supposed to doff PPE at the door. She said she was supposed to doff gown, face shield, gloves and the last thing was to wash her hands prior to exit. She said she was supposed to throw away the gown and gloves in the red biohazard bag by the door. She said she was disciplined for not wearing her mask properly. Record review of CNA B's in-service record titled: Personal Protective Equipment (PPE) Audit Tool dated 9/12/20 read in part . Identify and gather the proper PPE to don. Perform hand hygiene. Put on isolation gown. Put on NIOSH-approved N95. Put on face shield or goggles. Put on gloves. Doffing: remove gloves. Remove gown. Perform hand hygiene. Remove face shield or goggles. Remove and discard respirator (or facemask). Perform hand hygiene after removing the respirator/face mask . Record review of CNA B's disciplinary action form dated 9/12/20 read in part . failure to comply with PPE protocol . Record review of CNA B's in-service record dated 9/12/20 read in part . Objectives of the in-service: PPE, handwashing/wearing gloves and leaving unit unattended. CNA must stay on the unit; all other times must wear N95 mask always. Must don/doff PPE per guidelines . Record review of the facility's in-service record dated 9/11/20 read in part . Topic: Admission/Readmission QUARANTINE Hall. Wear PPE (gowns, gloves, mask, N95 (if possible)/KN95 and eye protection. Change gloves and gowns between every resident encounter. Eye goggle/face shields once disinfectant may be bagged and placed in the isolation cart. Eye goggles can be reused. Face shields will be discarded at the end of the shift (unless in crisis capacity and will be disinfected). N95 (if possible) are to be worn on quarantine hall. Hand hygiene will be performed prior to entering the isolation area/admission/readmission hall, leaving the room and isolation area/admission/readmission area, hand hygiene criteria will be followed. Doffing will be conducted prior to exiting the room . Upon further review, the training records indicated CNA B, E, F and G; LVN's A, B, RN and Activity Director were all in attendance. Staff validated competency through return demonstration. On 9/13/20 at 7:26 pm the facility's Administrator and DON were
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for residents, staff and public in 1 of 3 units (Unit 3) reviewed for environment in that: -Unit 3 had restrooms with sink faucets with no water running, air conditioners did not work, restroom floors/doors were dirty, and lights in rooms were flickering. -Common areas had restrooms that were dirty and unsanitary, ceiling tiles were broken/water stained, cold water faucet not working and gardens in the smoking area were peppered with cigarette buds. These failures could affect all residents that used common areas and residents in Unit 3 by placing them at risk for diminished quality of life due to the lack of well-kept environment. Findings include: Observation and interview on 9/11/20 at 8:45 am in occupied resident room [ROOM NUMBER] accompanied by Housekeeper revealed resident complaining to Housekeeper about her light over her bed because it flickered. She told the housekeeper she reported it weeks ago to CNAs, housekeeping, and maintenance. The Housekeeper confirmed the resident repeatedly told maintenance that her light had been broken. The sink faucet was broken and would not turn on. The A/C was not working. The Housekeeper said they opened the windows. The light fixtures had no pull chains. The call light was missing. The Housekeeper said maintenance took it out and never replaced it. Observation on 9/11/20 at 9:05 am of the facility's physical environment accompanied by Maintenance Director in the memory care (Unit 3) revealed the following dirty areas and disrepairs: -Vinyl baseboard was unglued and left on the floor between resident rooms [ROOM NUMBERS]. -Restroom by nurse's station outside of Unit 3 was dirty (caked soiled floors) and unsanitary (shredded toilet and paper towels on floor). The walls had dripping liquid stains that made the paint fade, so the wall appeared to look striped. The sink countertop was cracked, faded, and dingy and had a film of dirt. The restroom floor had a caked film of dirt that bordered about nine inches in width across the entire restroom floor. The floor behind the toilet look black in color from caked dirt. The paper towel dispenser was dirty with dust and liquid drip marks on the exterior of the dispenser. The vents on the ceiling had about 1/2 inch of layered dust that encompassed the entire vents. The ceiling tile where one of the vents was located was broken with the potential to cave. The cold-water faucet was not working. -Toilet paper holder broken in occupied resident room [ROOM NUMBER] and there was a dirty brown liquid splash (about 6 X 6 in size) on inside door of the room. -A/C did not work in occupied resident room [ROOM NUMBER]; no paper towels; and the restroom floor had a caked film of dirt that bordered about nine inches in width across the entire restroom floor. The floor behind the toilet look black in color from caked dirt. -The sink was backed up to the top in occupied resident room [ROOM NUMBER] and there was a hole the size of a door knob from the door not having a door [MEDICATION NAME]. The exit door had a layer of dirt on frequently touched areas. -A/C broken in occupied resident room [ROOM NUMBER]; lights in restroom were flickering; and the restroom floor had a caked film of dirt that bordered about nine inches in width across the entire restroom floor. The floor behind the toilet looked black in color from caked dirt. In a follow-up interview on 9/11/20 at 9:20 am with Housekeeper, she said she did housekeeping for Unit 3. She said her duties included cleaning the restrooms, sink, sweep and mop. She said she did not do buffing of the floor or scrub baseboards. She said the floor techs buffed the floors. She said the machine for buffing was broken. She confirmed the faucet in front of the nurse's station was broken. She said there were other faucets like the broken one in the restroom outside of memory care. She led the Surveyor to occupied resident room [ROOM NUMBER] and said, This sink backs up. She turned on the water to show this Surveyor how the water backed up. The water backed up to the top of the sink. She led this Surveyor to occupied resident rooms [ROOM NUMBERS] to reveal the air conditioners were not working. She said they opened the windows for the residents with broken air conditioners. She said some residents did not like it cold in their rooms. She said the protocol was to report anything broken to the Manager. She said she had reported the faucets broken on several occasions. She said she reported it to Maintenance too. The Housekeeper said it was everyone's responsibility to clean frequently touched areas. In an interview on 9/11/20 at 10:20 am with Maintenance Director, he said there was a maintenance log book. He said he was responsible for maintenance and housekeeping staff. He said all staff were responsible for reporting items in need of repair when they saw them. He said they were supposed to document their request on the log book. He said he handled all requests by priority level. He said first priorities would be related to water, a/c's, water leaks, toilet issues, lighting issues and bed mechanical issues. He said he was aware of a few toilets with low water pressure. He said any staff that saw things in disrepair should be reporting it because he had so much to do that he did not have the time for walk through inspections. He said resolution should occur immediately for priorities. He said he did not know who oversaw stripping the floors behind the toilets that look black in color from caked dirt. He said, But, whoever is in charge is under my supervision. He said he did not believe the facility had a written policy on maintenance requests. In an

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F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) interview on 9/11/20 at 10:25 am with Maintenance Assistant, he said his responsibilities were to supervise laundry and housekeeping staff. He said he was recently promoted (last month). He said he had 2 housekeepers and 2 floor techs under his supervision. He said one housekeeper cleaned hallway 1 and the common areas and the other housekeeper cleaned the other half of the facility. He said floor techs oversaw the dining room. He said he made sure his staff were taking care of their duties by conducting quick runs around the facility after breakfast, before lunch, and after shifts end. He said he felt that 2 housekeepers were not enough, so he helped. He said the restroom floors were supposed to be changed out about two months ago. He said the facility was beginning to swap out outdated old dirty stained floors but then COVID hit. He said the old dirty stained floors needed to be buffed. He said the buffer had been broken for about one month. Observation and interview on 9/17/20 at 10:35 am with Activity Director revealed the gardens in smoking area were peppered with cigarette butts. There were three garden areas, each about 150 to 200 square feet in size. There were countless number of cigarette butts that appeared to look like cigarette butts were being thrown into the garden areas for an extended period. The Activity Director said smoking times for residents were at 8:30 am, 10:30 am, 12:30 pm, 4:00 pm and 7 pm. The Activity Director said staff took turns supervising the residents during smoking times. She said she made sure cigarette butts were in the trash can. She said she did it for residents that could not do it for themselves. She confirmed the gardens were peppered with cigarette butts. She confirmed that there were countless number of cigarette butts in all three garden areas. She acknowledged that it appeared like the cigarette butts had gotten worse through time. She said maintenance would sweep the patio after each smoke break. She could not explain why the gardens were peppered with cigarette butts. In an interview on 9/17/20 at 10:43 am with the Laundry Aide, she said she would take cigarette butts from the residents and put them out when she supervised them. She said the floor techs were supposed to sweep after smoking times. Observation and interview on 9/17/20 at 10:50 am with Assistant Maintenance revealed him sweeping the cigarette butts in the gardens in the facility's designated smoking area. He said the floor techs were responsible for sweeping and picking up cigarette butts after smoking times. He confirmed the gardens were peppered with cigarette butts. He confirmed that there were countless number of cigarette butts in all three garden areas. He acknowledged that it appeared like the cigarette butts had been there for an extended period. He said maintenance swept the patio after smoking times. He could not explain why the gardens were peppered with cigarette butts. Policies and procedures were requested on 9/11/20 at 10:20 a.m. and on 9/17/20 at 10:35 am from the Maintenance Director for maintenance log book/maintenance request form and physical environment repairs, priority level system for repairs, cleaning/sanitation of physical environment. No policies and procedures were provided prior to exit. The facility did not have any written policies to ensure requests got transcribed on the facility's maintenance log.