| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676003 | A. BUILDING _____ B. WING _____ | 07/21/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| AZLE MANOR HEALTH CARE AND REHABILITATION | 721 DUNAWAY LN AZLE, TX 76020 |

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<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews, and record reviews, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (Resident #1 and Resident #2) of 10 residents reviewed for infection control practice. 1. The facility failed to prevent Resident #1 and Resident #2, both positive for COVID-19, from wandering off the designated COVID-19 unit multiple times, requiring the Administrator, DON, and Social Worker to interact with them and physically redirect them. The Administrator, DON, and Social Worker were not wearing full PPE, including gloves and gowns, when physically redirecting or interacting with Resident #1 and Resident #2 2. LVN F and MA AA failed to wear a mask correctly while on the facility's COVID unit to help prevent cross contamination. On 07/18/20 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 07/21/20, 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 Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. The facility was provided with the IJ template on 07/18/20 at 7:20 PM. This failure placed residents at increased risk of exposure to COVID-19, which could result in illness, hospitalization , or even death. Findings included: 1. Review of Resident #1's face sheet, dated 07/18/20, revealed the resident was a [AGE] year-old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. She also had a positive [DIAGNOSES REDACTED].#1's admission MDS (Minimum Data Set) assessment, dated 06/12/20, revealed the resident had a BIMS (Brief Interview for Mental Status) score of three indicating the resident was cognitively impaired.<br>The resident had a history of [REDACTED]. The resident also required supervision with bed mobility, transfers, and walking. Review of Resident #1's Physician Orders, dated 07/18/20, revealed the resident was to wear a wander guard signal device at all times for elopement precaution related to [MEDICAL CONDITION]. Review of Resident #1's Progress Notes from the Social Worker, dated 06/10/20, revealed the resident continued to wander throughout the facility. Review of Resident #1's Care Plan, dated 06/22/20, revealed the resident was at risk of wandering around the facility. Interventions included distractions by offering pleasant diversions, structured activities, redirection as necessary, and every 15-minute checks. Review of Resident #1's test results, dated 07/14/2020, revealed that she was positive for COVID-19. Observation on 07/18/20 at 3:10 PM revealed Resident #1 was down the hallway (approximately 20 feet) from the COVID-19 positive unit near the dining room. She was not wearing a mask and was touching the walls and doors in the dining room. The DON and Social worker attempted to redirect her back towards the COVID-19 positive unit. The DON and Social worker had physically touched the resident to help her back down the hallway. The DON provided the resident a surgical mask and helped to put it on her face. The DON and Social Worker retrieved Resident #1 to assist her back to the unit where unit staff escorted her from there. The DON and Social worker had on KN95 masks, but no gloves or gowns while interacting with Resident #1. The dining room was used for storing delivery carts used to serve meals to residents in the facility. Observation on 07/18/20 at 3:20 PM revealed Resident #1 was again down the hallway from the COVID-19 positive unit near the dining room. She had the surgical mask pulled down below her chin. The DON and Social worker attempted to redirect her back towards the COVID-19 positive unit where unit staff escorted Resident #1 from there. The DON and Social worker had physically touched her once again to help her back down the hallway. The DON and Social worker had on KN95 masks, but no gloves or gowns while interacting with Resident #1. Observation on 07/18/20 at 3:30 PM revealed Resident #1 had exited the doors to the COVID-19 positive unit where the Social Worker was leaving supplies outside the doors. The Social worker attempted to redirect her back through the doors where unit staff escorted Resident #1 from there. The Social Worker had on a KN95 mask, but no gloves or gown while interacting with the resident. An interview with the Administrator on 07/18/20 at 3:45 PM revealed Resident #1 was a known wanderer and would walk around the facility before she was placed on the unit. He acknowledged that the resident came out of the unit not wearing a mask or not wearing it above her mouth and nose. He said that he did not come into physical contact with her but that the DON and Social Worker did. He said that he did not change his mask after being around her and was not wearing gloves or a gown. He said that he was not aware that she had been wandering out of the unit until today (07/18/20). He said that she was supposed to be involved in activities to keep her occupied and that staff were to be keeping a close eye on her. He said that he could put her on one-to-one supervision or have her sit at the nurse's station so staff could keep a closer eye on her but he was not sure about those interventions. An interview with the Social Worker on 07/18/20 at 4:00 PM revealed Resident #1 was a known wanderer and would walk around the facility before Resident #1 was placed on the unit. She acknowledged that the resident came out of the unit not wearing a mask or not wearing it above her mouth and nose. She said that she did come into physical contact with Resident #1 while helping her down the hallway. She said that she did not change her mask after coming into contact with the resident and did not have gloves or a gown on. An interview with the DON on 07/18/20 at 4:10 PM revealed Resident #1 was a known wanderer and would walk around the facility before Resident #1 was placed on the unit. She said that Resident #1 was supposed to be involved in activities to keep her occupied and that staff were to be keeping a close eye on her. She acknowledged that the resident came out of the unit not wearing a mask or not wearing it above her mouth and nose. She said that she went to get Resident #1 a surgical mask and put it on her as quickly as she could. She said that she did come into physical contact with Resident #1 while helping her down the hallway. She said that she did change her mask and sprayed herself with Lysol (disinfecting spray) after coming into contact with the resident. She said that she did not have gloves or a gown on when interacting with the resident. An interview with the DON on 07/18/20 at 5:20 PM revealed that Resident #1 should not have left the unit and staff should have been watching Resident #1 more closely. She said that all staff on the unit knew of Resident #1's wandering habits. She said the concern was that the resident was positive for COVID-19 and could have infected others in the building by coming out of the unit, especially without a mask on. She said she knew she should have put a gown and gloves on in order to touch Resident #1, but she had not thought about it at the time. An interview with the Administrator on 07/18/20 at 5:30 PM revealed that Resident #1 should not have left the unit and staff should have been watching her more closely. He said that all staff on the unit knew of Resident #1's wandering habits. He said the concern was that the resident was positive for COVID-19 and could have infected others in the building by coming out of the unit, especially without a mask on. An interview with the Social Worker on 07/18/20 at 6:49 PM revealed she changed her mask after coming into contact with Resident #1 and acknowledged that she should have been wearing gloves and a gown when interacting with Resident #1 but did not think about it. Review of Resident #2's face sheet, dated 07/20/20, revealed the resident was a [AGE] year-old female admitted on [DATE]. Her [DIAGNOSES REDACTED]. She also had a positive [DIAGNOSES REDACTED]. The resident had a history of [REDACTED]. Review of Resident #2's Care Plan, dated 05/21/20, revealed the resident was at risk of wandering which significantly intruded on the privacy of others. Interventions included distractions by offering pleasant diversions, structured activities, food, conversation, television, books. The care plan also addressed Resident #1 was positive for COVID-19 and would remain on isolation to prevent the risk of spread. Interventions included adhering to PPE requirements for droplet and contact precautions, N95 masks rather than surgical or |

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<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>cloth, face shields/goggles, gloves, and gowns. Review of Resident #2's Progress Notes from RN BB, dated 07/15/20, revealed the resident had been up and about and in and out of her room since the beginning of the shift, and all non-pharmacological methods were unsuccessful. Observation on 07/19/20 at 2:25 PM revealed Resident #2 had exited the doors of the COVID-19 positive unit and was down the hallway (approximately 20 feet away from the COVID positive unit) near the dining room. She was not wearing a mask. The DON, Administrator, and Social Worker attempted to redirect Resident #2 back towards the COVID-19 positive unit. The DON had donned a gown, the Social Worker was wearing a single glove, and the Administrator left to get gloves for both of them. All three were wearing KN95 masks. An interview with the DON on 07/19/20 at 3:15 PM revealed Resident #2 was not a wanderer but did become confused at times. She said that Resident #2 should not have left the COVID-19 unit and was not sure how Resident #2 got out. She said that after speaking with the resident's family on the phone, Resident #2 went back to the unit and to her room. The DON said that she was wearing a gown and gloves with the resident and changed her mask afterwards. She said that the Administrator and Social Worker left to go home and change clothes to reduce the risk of cross-contamination. An interview with the Administrator on 07/19/20 at 3:25 PM revealed Resident #2 was not a wanderer but did become confused at times. He said that Resident #2 should not have left the COVID-19 unit and was not sure how she got out. He said that he called the resident's family on his phone and let them speak to her. He said that Resident #2 calmed down and was directed back to the unit after that. He said that he and the Social Worker wore gloves while in contact with the resident and the DON was wearing a gown and gloves. He said that he and the Social Worker left to go home to change clothes to prevent cross contamination. He said that he also changed his mask. Review of the CDC's (Center for Disease Control) Guidance on Considerations for Memory Care Units in Long-term Care Facilities: When residents on a memory care unit are suspected or confirmed to have COVID-19 .If residents with COVID-19 will be moved from the memory care unit .prepare personnel on the receiving unit about the habits and schedule of the person with dementia and try to duplicate it as much as possible. Accessed from https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html. Review of the facility's undated policy, titled Infection Control- Respiratory Infection [MEDICAL CONDITION] (COVID-19), revealed .If a resident comes out of their room they will be asked to wear mask provided- either a cloth mask or surgical mask .if a resident refuses the mask attempts will be made to re-direct back to their room .staff will attempt to keep the residents in their room during this time except for showers .wandering residents will be redirected as possible to their room and if out of their room staff will attempt to keep them 6 feet (social-distancing) from other residents and staff. 2. Observation on 07/18/20 at 1:54 PM revealed MA AA entered the COVID-19 positive unit without a mask on. She passed a resident on the unit who was wearing a mask and walked to the nurse's station where other employees were seated wearing masks, gowns, face shields, and hair covers. An interview with MA AA on 07/18/20 at 4:45 PM revealed she did not wear her mask when entering the COVID-19 positive unit earlier today because her hands were full. She said she knew she was supposed to wear her mask at all times. She said she was supposed to don her mask at the door and should have set her items down to do so but she did not. She said that the purpose of wearing a mask was to reduce the spread of infection. Observation on 07/18/20 at 2:40 PM revealed LVN F sitting at the nurse's station on the COVID-19 positive unit with his mask pulled down below his chin. There was a resident nearby in a wheelchair asking LVN F a question. An interview with LVN F on 07/18/20 at 5:00 PM revealed he had his mask off earlier and did so to speak with a resident or on the phone. He said that he pulled it below his chin and it was not covering his mouth or nose. He said that he only worked on the COVID-19 positive unit. He said he knew it was not the right thing to do. He said that the purpose of wearing a mask was to reduce the spread of infection. An interview with the DON on 07/18/20 at 5:20 PM revealed that all staff were to wear their masks at all times. She said that masks should be over their noses and mouths but it was a constant battle. She said that staff working on the COVID-19 positive unit should especially be wearing their mask so not to spread the infection. She said that all staff have been trained, talked to, and in-serviced on wearing masks. An interview with the Administrator on 07/18/20 at 5:30 PM revealed that all staff were to wear their masks at all times. He said that the masks should be over their noses and mouths. He said that staff working on the COVID-19 positive unit should definitely wear their masks so not to spread the infection. He said that staff have been talked to and trained on wearing masks. He also said that staff are at times shared between the positive unit and the general population side. He said that they were short staffed and there was potential for staff to work both sides on different shifts. Review of the CDC (Center for Disease Control)'s Guidance on Preparing for COVID-19 in Nursing Homes revealed: Implement Source Control Measures .HCP (Healthcare Personnel) should wear a facemask at all times while they are in the facility .facemasks offer both source control and protection . Accessed from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html Review of the facility's undated policy, titled Infection Control-Respiratory Infection [MEDICAL CONDITION] (COVID-19), revealed .Staff will wear the appropriate PPE to the area and clientele they are working with .if working in a 'Covid Unit' staff will wear the PPE throughout the shift- gown, mask, gloves and goggles or face shield. An IJ was identified on 07/18/20, and the Administrator and DON were notified of the IJ. A plan of removal to remove the immediacy was requested on 07/18/20 at 7:15 PM. The following plan of removal was accepted on 07/19/20 at 5:13 PM. Issue of Non Compliance: 1) Two staff members not wearing masks in COVID unit Facility will re-educate facility staff and agency staff on wearing of appropriate PPE at all times for COVID Unit and Non Covid unit. The education is being conducted by Administrator, DON, ADON, and nursing Management staff. This education began on 7-18-2020 at 8 pm and is continuing at this time, it will continue until 7-21 and then any staff not here (whether on vacation or because of Covid) will be educated and sign the acknowledgement on their return prior to entering their assigned halls. Education will be ongoing as new staff are hired. Facility will have all staff sign Infection Control Acknowledgement statement, this form will be signed after they are educated and will acknowledge the education and understanding. The form was started being signed on 7-18-2020 at 8 pm when the education began and is continuing. Facility will monitor for compliance by Administrator, DON, ADON, and Supervisory staff on an ongoing basis. 2) Wandering resident left the COVID unit three times on 7-18-20; On 7-19-20 another resident became belligerent and forced her way out of the unit staff immediately contained her, secured the area and after speaking with her daughter were able to return her to the unit. The area she went in was sanitized and kept closed after being fogged with an anti [MEDICAL CONDITION] (Covid) solution with a 10 minute wet time and the doors kept closed for 30 minutes. Staff will be educated on close observation of the resident and redirection as needed, this education began on 7-18-2020 at 8 pm and is continuing. This education is being conducted by Administrator, DON, ADON, and Nursing management staff. Any staff currently off (whether vacation or due to Covid) will be educated on their return prior to entering their assigned halls. Staff will attempt to keep the wandering residents in their room as possible Staff will offer snacks, ice cream, drinks to those wandering residents. Staff will provide and observe each wandering resident or a resident with the potential to wander for wearing of mask, with reminders and assistance as needed Staff will encourage and assist the wandering residents or residents with the potential to wander to sit in smoke room with magazines or puzzles and coloring books, this morning the first resident was able to sit and color for a period of time. The residents in the smoke room will be limited to three to maintain six foot distancing Staff will attempt to keep the wandering residents or those with the potential to wander in direct line of sight when not in their rooms. Staff will redirect the wandering residents or those with the potential to wander to the TV area, Smoke Room, at nurses' desk, or their room as needed. The Social Worker and Activity Director will assess all residents for the potential to wander and develop an individualized plan of activities which will be carried out by the staff in the unit. This assessment will start on 7-19 and be completed by 7-22-20 These plans will be implemented today (7-19-20) and continue on an ongoing basis until 7 days after the Covid unit is closed. As new residents are admitted they will be assessed for the potential to wander and plans of care developed and implemented for them. If the resident is moved to another room or station the same plan will be in place. If another resident begins to wander the same actions of monitoring, redirection, offering of snacks, observation, keep in line of sight, will be put into place for them. Wandering residents will also be monitored for their location by the cameras in the hallways. This education is for both facility and agency staff. This will be monitored by the Administrator, DON, ADON, and Nursing Supervisory staff, Activity Director and the Social Worker on an ongoing basis. The actions in this plan of removal were begun on 7-18-2020 and will continue until all staff are educated, new staff will be educated as they are hired. Monitoring of the plan of removal included the following: Observations made on the COVID positve unit from 07/20/20 to 07/21/20 revealed two staff members in full PPE (personal protective equipment) sat outside the doors to the unit. Also, staff were observed redirecting residents back to their rooms and encouraging or assisting them in wearing masks. Interviews were conducted on 07/19/20 to 07/21/20 with the following staff: the Administrator, the DON, the ADON, the Social Worker, CNA A, LVN B, MA C, LVN D, LVN E, LVN F, CNA G,<br>CNA H, MA I, CNA J, MA K, CNA L, CNA M, CNA N, LVN O, LVN P, LVN Q, CNA R, CNA S, CNA T, LVN U, CNA V, LVN W, CNA X, CNA Y, CNA Z. These interviews with staff confirmed they had been in-serviced and were able to articulate the proper use of PPE |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 2)<br>and how or when to wear their mask. The staff revealed residents who exhibited wandering behaviors or the potential to wander were to be monitored closely and redirected quickly. The staff also stated their understanding of what monitoring and redirection consisted of. On 07/18/20 an Immediate Jeopardy (IJ) was identified. While the IJ was removed on 07/21/20, 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 Jeopardy with a scope of isolated due to the facility continuing to monitor the implementation and effectiveness of their plan of removal. |