STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675046	A. Building B. Wing	12/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosenberg Health & Rehabilitation Center	1419 Mahlman St Rosenberg, TX 77471

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46678 Based on observation, interview, and record review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment for 1 of 13 resident rooms reviewed for homelike environment. 1. The facility failed to clean the floor and wall in Resident #29's room. 2. The facility failed to provide clean linens for Resident #29's bed. These failures could affect all residents by decreasing their sense of self-worth. Findings include: Review of Resident #29's electronic face sheet dated 12/30/23 revealed he was admitted to the facility on [DATE] with diagnosis of osteomyelitis (inflammation of bone caused by infection), pressure ulcer of sacral (the bottom of the spine and lies between the fifth segment of the lumbar spine and the tailbone) region, paraplegia, neuromuscular dysfunction of bladder, and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). During an observation on 12/27/23 at 11:20 AM of Resident #29's room, on the floor there were candy wrappers, food crumbs, droplets of a dried brown substance, and a jacket. The wall behind the resident's bed had about 7 round yellowish-brown stains. There was also a dried red substance on the resident's sheets. During an observation and interview on 12/28/23 at 3:25 PM, Resident #29's floor was clean, there were new bed sheets on the bed, the round yellowish-brown stains were on the wall behind the resident's bed. Resident #29 said the room was finally cleaned after the state came in. He said the yellowish-brown substance on the wall was hot sauce and housekeeping staff did not attempt to clean the wall. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/29/23 at 4:50 PM with the Housekeeper, she said each employee has a hall and all the rooms were cleaned once a day. She said the cleaning staff were not supposed to touch personal items, and if the bed linens were soiled, the CNAs were responsible for changing the bed sheets. She said Resident #29 got upset if staff touched his personal belongings. She said when Resident #29 used to live on Hall 500, which was her assigned hallway, she would make sure Resident #29's floor was cleaned. She said she was not sure who was assigned to hall 200 where he currently lived but did state housekeeping had been short staffed due to COVID. Record review of the Statement of Resident Rights not dated read in part . residents have the right to safe, decent, and clean conditions A housekeeping policy was requested on 12/29/23 at 4:58 pm but was never received.

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48605 Based on observation, interview, and record review, the facility failed to maintain an infection control program designed to prevent the development and transmission of infection for 25 of 30 residents (Resident #204, #206, #92, #78, #9, #77, #73, #67, #39, #71, #74, #75, #20, #7, #44, #36, #50, #14, #30, #16, #82, #88, #70, #94, and #38) reviewed for infection control. The facility failed to ensure that Residents (#44, #36, #50, #14, #30, #16, #82, #88, #70, #94, and 38) who received negative COVID test results were not accommodated in a shared room alongside Residents(Resident #92, #78, #9, #77, #73, #39, #71, #74, #75, #20 and #7) who had tested positive for COVID 19 and were identified as droplet isolation precaution Residents. The facility failed to ensure transmission-based precaution protocols evidenced in the inadequate placement of notices and insufficient provision of Personal Protective Equipment (PPE) in the vicinity of residents' rooms or within their immediate proximity for the following residents: (Resident 71), (Resident #20), (Resident #74), (Resident #42), (Resident #75), (Resident #39), (Resident #67), (Resident #73), (Resident #7), (Resident #77), (Resident #9), (Resident #78), (Resident #92), (Resident #206), and (Resident #204). The facility failed to ensure that staff (CNA T and CNA J) implemented appropriate use of PPE and transmission-based precautions prior to enter and exiting residents' (Resident #91, #80, #74, #71, #77, and #92) rooms. The facility failed to ensure staff (CNA T, CNA J and ADON A) wash or sanitize hands after providing care to Residents (Resident #91, #80, #71, #74, #77, #92, and #352) rooms. An Immediate Jeopardy (IJ) was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 1:45p.m. While the IJ was removed on [DATE] at 2:05p.m, the facility remained out of compliance at a scope of pattern and a severity level of Actual harm that is not Immediate Jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems. These failures have the potential to affect residents by placing them at an increased and unnecessary risk of exposure to communicable diseases and infections. Findings included: Record review of Resident #204's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #206's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #92's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #78's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #9's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #77's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #73's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #67's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #39's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #71's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #74's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #75's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #20's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #7's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old; Resident had a diagnosis of COVID 19 (an acute disease in humans caused by a coronavirus, which is characterized mainly by fever and cough and is capable of progressing to severe symptoms and in some cases death, especially in older people and those with underlying health conditions) dated [DATE]. Record review of Resident #82's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old with primary diagnosis of metabolic encephalopathy (a problem in the brain, caused by a chemical imbalance in the blood). Record review of Resident #44's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old with a primary diagnosis of polyosteoarthritis (a common type of arthritis that affects many joints at once, causing pain, swelling, and stiffness). Record review of Resident #36's face sheet dated [DATE] revealed resident was admitted to the facility on [DATE], age [AGE] years old with primary diagnosis of Chronic Kidney Disease (occurs when a disease or condition impairs kidney function). Record review on [DATE] of lab results and clinical charts for Residents #204, #206, #92, #78, #9, #77, #73, #67, #39, #71, #74, and #75 revealed positive COVID 19 nasal swab results dated [DATE]; and indicated the identified residents were all under droplet isolation precautions. Record review on [DATE] of lab results and clinical charts for Residents #44, #50, #14, #30, #16, #83, #88, #70, 94, and #38 revealed negative COVID 19 nasal swab results dated [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review on [DATE] of lab results and clinical chart for Resident #20 revealed positive COVID 19 nasal swab results dated [DATE]; and indicated the identified resident was under droplet isolation precautions. Record review on [DATE] of lab results and clinical chart for Resident #36 revealed negative COVID 19 nasal swab results dated [DATE]. Record review on [DATE] of lab results and clinical chart for Resident #7 revealed positive COVID 19 nasal swab results dated [DATE]; and indicated the identified resident was under droplet isolation precautions. Record review on [DATE] of lab results and clinical chart for Resident #82 revealed negative COVID 19 nasal swab results dated [DATE]. Record review of facility's infection control tracking and trending log dated [DATE] revealed no documented tracking of Staff and Residents who tested positive for the COVID19 for the month of [DATE]. Record review on [DATE] at 4:00 pm the facility furnished test outcomes from [DATE]st, 23rd, and 26th, 2023, indicating positive COVID 19 test results for 14 residents (Residents #204, #206, #92, #78, #9, #77, #73, #67, #39, #71, #74, #75, #20, #36, and #7). Record review resident roster and observations on [DATE] revealed that these identified positive COVID 19 residents resided in various location on all designated halls (100 hall, 200 hall, 300 hall, 500 hall, and 600 hall) reserved for the facility's residents, and were accommodated in a shared room alongside Residents (#44, #36, #50, #14, #30, #16, #82, #88, #70, #94, and 38) who had tested negative for COVID 19 as of [DATE]. Observation, record review and interview on [DATE] at 09:30am revealed that there were no droplet isolation precaution postings and insufficient PPE observed in or around Resident #71's room and the door. Resident #71 resided on the 100 hall of the facility, in shared room [ROOM NUMBER] with Resident #44. Both Resident #71 and Resident #44 were observed inside the designated room # 1 with the room door open at that time. Resident #71 was lying in bed without a facemask. Resident # 44 was sitting in a chair without a facemask. Resident #44 was interviewed at the time of observation and stated that he had tested negative for COVID 19 last week on [DATE] but was told that he had to continue to cohort with Resident #71 who had tested positive on the same date ([DATE]). Resident #44 stated that he was not provided a facemask and was afraid that would get sick from Resident #71. Resident # 44 stated that he had shared the concern with the facility staff, but various unidentified staff never provided him with a facemask and told him that he had to continue to reside in the room with positive COVID 19 Resident #71. Observation on [DATE] at 12:15PM revealed Resident #19 in her room being fed by Staff Z. Staff Z had a surgical mask on. In an interview with Staff Z at 12:15 PM, he said he does not know if Resident #19 was positive for Covid or not. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview conducted on [DATE], at 9:13 am, ADON B stated that the administrator was absent due to a doctor's appointment. ADON B also reported the presence of active COVID-19 cases within the facility; initially detected on [DATE]. ADON B stated he was uncertain regarding the number of residents and staff who tested positive for COVID-19 and was also unsure about the total number of residents tested for the virus. Interview on [DATE] at 9:29 am, Nurse A, the nurse assigned to hall 6, stated that only rooms [ROOM NUMBER] on the 600 hall and were COVID 19 Isolation rooms. Nurse A stated that they were out of supplies and administration staff had not restocked the PPE. It was not identified how long the facility had been out of supplies. Interview with the DON, on [DATE] at 1:00pm stated she and the Administrator were informed by the Regional Nurse on [DATE] that Residents who tested positive for COVID 19 should remain in the rooms with those residents who had tested negative for COVID 19. The DON also revealed that she had been out of the facility since [DATE], as the DON, ADON A, and ADON B tested positive for COVID on [DATE]. She stated that she returned to the facility on [DATE] just prior to the interview. The DON also revealed that Resident #19 was positive with COVID. Observation on [DATE] at 1:30PM, revealed two facility staff moving residents from the 100 halls. Both staff had a face max on no other form of PPE was observed. In an interview with the two staff on at 2:30PM, Staff X and staff Y said they were asked by the facility Administrator to move all the covid positive residents to the 200 halls with the positive residents and leave the negative residents in their room. Staff Y said he tested positive on [DATE]. He said he had some symptoms flue-like on [DATE] and took covid test on [DATE]. He said the test was positive for covid. He said at that time, he called the facility to inform the DON and Administrator that he had Covid. He said he was asked to stay home for 5 days. He said he came back to work on [DATE] During the Resident Council Meeting on [DATE] at 2:30 p.m., Resident #28, was very emotional after learning that there were several people in the facility with COVID. His eyes started watering and he said, I have been in the hospital for 5 months and almost died . I have seen people die around me, and they aren't telling us anything. Resident #59 said, there is no designated COVID hall, and they are not transferring people out of rooms who are negative and COVID is spreading. Resident #17 said, Yes, it's spreading, and I don't have my 2nd COVID Booster. Record review on [DATE], of clinical chart revealed that Residents (#28, #59, and 17) who attended the Resident Council meeting was pending COVID results in Point Click Care. Interview on [DATE] at 3:00 pm with the Administrator and IP A (also identified as ADON A) who stated that had been trained on transmission-based precautions and is responsible for the tracking a trending of communicable diseases within the facility. Documentation of the IP A's trainings was requested at the time of the interview. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview [DATE] at 4:45 pm with Nurse A, the nurse assigned to hall 6, stated she worked part time at the facility for 1 Year. She stated that she had not complete COVID 19 training but had been trained on airborne precautions. Nurse A stated that the person who initially set up the COVID Isolation rooms, did not set them up correctly. She stated there were negative and positive residents in the same room, and the risk of having them in same room can cause a spread in COVID 19 to other residents. Nurse A stated that not washing and sanitizing hands and having the correct PPE could also cause spread in COVID 19. Interview on [DATE] at 3:42 pm, CNA O stated that she started working at the facility one month ago. CNA O stated that she completed skill competencies and training with a nurse upon hire, but she was not able to articulate or identify what competencies and training were completed. CNA O stated that the supply person or administration staff would normally stock the door with PPE each morning. CNA O stated that the correct PPE was not provided or stoked on the door yesterday, [DATE] morning when she was entering and exiting rooms and no bags were in rooms for doffing PPE. Interview with the Administrator on [DATE] at 4:00 pm, the administrator revealed updated information regarding the facility' s identified Infection Preventionist. The Administrator stated that IP A had not completed the CDC required training, Nursing Home Infection Preventionist Training Course. The Administrator stated that as of [DATE] the DON was the designated the IP. The Administrator state that no one had been monitoring the tracking and trending of the COVID 19 infection in the facility. The Administrator stated that she DON and ADON A had been out sick for at least 5 days since both had tested positive on [DATE]. Record review on [DATE] at 4:00 pm the facility furnished test outcomes from [DATE]st, 23rd, 26th, and 28th 2023, indicating positive COVID 19 test results for 29 residents. The total number of COVID 19 positive Residents had doubled from the previous test results. Interview on [DATE] at 4:12 pm with the Administrator and the DON, the Administrator stated that they would be moving residents that are negative out of rooms with individuals who are positive and notifying families. The Administrator stated that this process is late due to the misinterpretation of the policy, and the information that they received from the Regional Nurse consultant who advised the Administrator and the DON to not designate a hot zone (a designated hall for COVID positive residents) and to not move negative residents who were placed in cohort rooms with COVID positive residents. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 4:25 with the Regional Nurse who stated that she informed the Administrator to isolate, place signage on doors, and test on days 1,3, and 5. She stated that on [DATE], she informed the Administrator and the DON to keep positive COVID residents in a cohort room with negative COVID because the negative residents had already been exposed to positive residents. Regional Nurse stated that this was the facility policy. During the interview, the Regional Nurse and the surveyor team reviewed facility's policy titled Novel Coronavirus Prevention and Response Section 8, Procedure when COVID -19 is suspected or confirmed, Letter F, page 5 indicated Do NOT cohort residents with other residents with COVID 19 infection unless they are also confirmed to have COVID 19 infection through testing. Regional Nurse stated that she had previously, on [DATE] misinterpreted the policy and had advised the Administrator and the DON based on the initial previous interpretation of the written policy. The Regional Nurse stated that she had been trained on transmission-based precautions and is responsible for the tracking a trending of communicable diseases within the facility. The Regional Nurse stated as result of her misadvising the Administrator and the DON the facility staff and Residents were placed at risk for being infected with COVID 19. Observation on [DATE] at 5:00 am, CNA T was observed entering droplet precaution room [ROOM NUMBER] without Personal Protective Equipment (PPE) and proceeded to administer incontinent care to Resident #91 while wearing gloves. Subsequently, after concluding the care, CNA T neglected to remove the gloves, sanitize or wash her hands before attending to Resident #80, assisted in adjusting the resident in bed. She returned to the designated clean linen cart with contaminated gloved hands, removed linen, and interacted with the cart without prior hand hygiene. Using the same contaminated gloves, CNA T proceeded to touch the doorknob of room [ROOM NUMBER], then entered room [ROOM NUMBER] without additional PPE (N95, gown, and face shield), continuing to provide incontinent care and emptied Resident #71's urinal. Following this, CNA T omitted hand washing and proper hand hygiene measures before attending to Resident #74, assisted the resident with a blanket. Droplet precaution room [ROOM NUMBER] door remained open. Interview on [DATE] at 5:43 am, CNA T expressed uncertainty regarding why PPE was not utilized, and hand hygiene practices were neglected. CNA T stated that Residents #91, #81, #71 and #74 were on Droplet Precautions due to testing positive for COVID 19. CNA T also acknowledged the risk of infection transmission in the absence of proper PPE and hand hygiene measures. CNA mentioned undergoing infection control training previously but was unable to articulate the specifics or content of the training provided. CNA T stated that she had received training on providing incontinent care to Residents. Observation on [DATE] at 5:05am, CNA J was observed entering identified Droplet Precaution rooms (room [ROOM NUMBER] and room [ROOM NUMBER]) without the appropriate Personal Protective Equipment (PPE), including face shields, N95 masks, and gowns, while providing incontinent care to Residents #77 in room [ROOM NUMBER] and Resident #92 in room [ROOM NUMBER]. Upon exiting room [ROOM NUMBER], proper hand hygiene measures were not implemented. CNA J did not wash or sanitize her hand after exiting Residents #77 room before she provided care to Resident #92. Interview on [DATE] at 5:15am, CNA J acknowledged the error of failing to don PPE and wash hands. CNA J stated that Resident #77 and Resident #92 were on Droplet Precautions due to testing positive for COVID 19. She verbalized an understanding that the transmission of infection can occur when PPE and hand hygiene protocols were not followed. She stated that such error put residents and staff at risk for infection. CNA J mentioned receiving infection control training, some time ago, but was unable to specify the content covered during the training sessions. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview on [DATE] at 8:11AM, the DON stated Resident #50 and Resident #83 were newly diagnosed as COVID positive as of [DATE]. The DON stated they should have followed the same protocol as before; it worked before. The DON stated the facility should have followed CDC guidelines not to room negative residents with positive residents. The DON stated they kept the negative and positive residents together because the Administrator and the DON were instructed to do so, by the Regional Nurse. The DON continued and stated that the Regional Nurse rationale was that the residents were already exposed and there was no reason to move them. The DON stated that the system failure placed Residents were placed at risk for being infected with COVID 19. The DON stated that the facility was working to ensure that all isolated rooms were stocked with proper PPE and signage. The surveyor informed the DON that staff had been observed entering rooms without PPE and was not implementing hand hygiene before and after care. The surveyor inquired but the DON's expectation related that to hand hygiene and the donning PPE. The DON stated that staff had been in-serviced and trained on proper hand hygiene and PPE. The surveyor required documentation of staff trainings. Interview on [DATE] at 12:00pm, the Administrator stated staff were notified of the COVID 19 outbreak on [DATE]. The Administrator stated that she was not able to verify how the staff was notified and who notified staff. The Administrator stated the floor nurses were monitoring residents for signs/symptoms and were made aware they were responsible, and doctors' orders to assess all residents for signs and symptoms had been added to the PCC. The Administrator could not articulate a plan to mitigate the risk at the time of the meeting. The Administrator stated that the Epidemiology Department had not been notified of the COVID 19 outbreak at the time of the interview. The Administrator did not reveal why the information had not been reported. The Administrator stated that the Business Office Manager is responsible for reporting to Epidemiology Department. Interview on [DATE] at 12:40, the Business office Manager stated that she was made aware of COVID positive residents at the facility on [DATE] when she returned to work. She stated that she had been out of the facility the previous week due to a personal family member's death. She stated that in her absence, the Administrator is supposed to report COVID 19 to the health department. Business office Manager stated that a report was submitted to the health department on [DATE] that included 14 residents who tested positive for COVID 19 on [DATE] and not for the total 29 residents that were currently in the building. The facility failed to provide failed to provide proof of in-services and staff training for infection control and transmission-based precaution requested on [DATE], [DATE], and [DATE] at various times. requested as of [DATE]. Thes was determined to be an immediate jeopardy (IJ) on [DATE] due to the above failures. The administrator was notified and provided the IJ template on [DATE] at 1:45p.m. The immediacy was lowered on Sunday, [DATE] at 2:05p.m. with the facility Administrator and DON, the facility remained out of compliance at a scope of pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of the corrective systems. Plan of Removal - Infection Prevention and Control 1. Immediate Action Taken (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675046	A. Building B. Wing	12/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosenberg Health & Rehabilitation Center	1419 Mahlman St Rosenberg, TX 77471

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(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 to resident health or safety Residents Affected - Some	A. On [DATE] the DON/designee moved all COVID positive residents to hall 200 that will serve as a dedicated COVID unit for all residents who are COVID Positive. B. On [DATE] roommates with high exposure to COVID positive residents are being monitored every shift by license nurse for signs/symptoms of COVID with documentation on LN MAR. All other residents are being monitored for signs/symptoms of COVID through License Nurse rounds during shift. Asymptomatic residents with a higher-risk exposure, will have a series of 3 viral tests for SARS-CoV-2 infection. Testing will be done immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. (This will typically be at day 1 (when day of exposure is day0), day 3, and day 5). Then testing will be repeated every ,d+[DATE] days until no new cases are identified for at least 14 days. C. On [DATE] residents in Isolation for COVID had appropriate signage placed on door (Contact Isolation signage, Droplet Isolation signage, and Donning and Doffing PPE signage) to alert staff of required PPE. D. On [DATE] residents who tested positive for COVID, had physician notification and orders received to place residents in Droplet Isolation. Each resident in Isolation had appropriate and adequate PPE outside of each room. This will be replenished as needed E. On [DATE] the DON who is currently the designated Infection Preventionist for the facility received 1:1 education on the Infection Preventionist Job duties that include: Education, training, experience, or certification in infection control and prevention. Completed specialized training in infection prevention and control through accredited continuing education. Develop and implement an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infections to provide a safe, sanitary, and comfortable environment. Establish facility-wide systems for the prevention, identification, reporting, investigation, and control of infections and communicable diseases of residents, staff, and visitors. Develop and implement written policies and procedures in accordance with current standards of practice and recognized guidelines for infection prevention and control. Oversee the facility's antibiotic stewardship program. Oversee resident care activities that increase risk of infection (i.e., use and care of urinary catheters, wound care, incontinence care, skin care, point-of-care blood testing, and medication injections). Lead the facility's Infection and Prevention Control Committee. Develop action plans to address opportunities for improvement. Participate on the facility's QAA Committee. Perform duties as assigned. F. The Infection Preventionist will use a system of surveillance to utilized prevention, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon a facility assessment and accepted national standards G. On [DATE] the facility assigned dedicated staff to the COVID unit. This will be ongoing until outbreak is over to the extent possible 2. Identification of Residents Affected or Likely to be Affected: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A. On all other residents were tested for COVID-19 with only 1 other resident identified who tested COVID positive. Total COVID-19 residents 29. 3.Actions to Prevent Occurrence/Recurrence: A. On [DATE] the DON/Designee started In-Service education with all staff on the Coronavirus Prevention and Response Plan that: Prompt identification, treatment to prevent the spread, source control, community surveillance, signs/symptoms to report and notify physician, testing considerations, response to an Outbreak, Hospital Admission Levels prevention, interventions to prevent respiratory germs into the facility, procedure when COVID-19 is suspected or confirmed, Managing /staff with High Exposure, return to work criteria for HCP and duration of transmission-based precautions for residents. This education will be completed on [DATE] at 7:30 pm, and no staff will be allowed to work until they have completed this education. This education will be provided to all newly hired staff ongoing. B. On [DATE] the DON/Designee started In-Service education with all staff on Transmission-Based Precautions Policy that: Defines different Isolation Precautions, standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission, when to Initiation of Transmission-Based Precautions, Discontinuation of Transmission-Based Precautions, Recommended PPE for each type of precaution. This education will be completed on [DATE] at 7:30 pm, and no staff will be allowed to work until they have completed this education. This education will be provided to all newly hired staff ongoing. C. On [DATE] the DON/Designee started In-Service education with all staff Hand Hygiene Policy that: D. Defines what hand hygiene is, when to perform hand hygiene versus using alcohol-base hand rub, technique, when to change gloves. This education will be completed on [DATE] at 7:30 pm, and no staff will be allowed to work until they have completed this education. This education will be provided to all newly hired staff ongoing. E. On [DATE] the DON/Designee started skills validation reviews with all staff on Hand Hygiene and the Use of PPE. These skills competencies will be completed on [DATE] at 7:30 pm, and no staff will be allowed to work until they have completed this education. These skills competencies will be provided to all