STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675620	A. Building B. Wing	01/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Nursing and Rehabilitation	1175 Denton Dr Beaumont, TX 77707

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse of residents were reported immediately to the administrator and to HHSC within the 2-hour period for 8 of 11 residents (Resident #1, #2, #3, #4, #5, #6, #7, and #14) reviewed for abuse. The facility failed to ensure allegations of resident-to-resident altercations and resident and staff altercations were reported immediately to the administrator and to the State Agency no later than 2 hours after the incident occurred or was suspected. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress. Findings included: 1.Record review of a face sheet dated 1/9/2024 indicated Resident #1 was 77-years-old, initially admitted to the facility on [DATE] with readmitted [DATE]. Her diagnoses included schizoaffective disorder, bipolar type (mental health condition with a combination of symptoms of schizophrenia and mood disorder), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), drug-induced tremor (involuntary shaking due to the use of medicines), Alzheimer's disease (a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of a MDS assessment dated [DATE] indicated Resident #1 was able to make herself understood and understand others. She had a BIMS of 15 (cognitively intact). She required supervision for most ADLs . She was frequently incontinent of bladder and bowel. Record review of Resident #1's care plan dated 4/23/2021 indicated Resident #1 has potential to demonstrate verbally abusive behaviors. Interventions included to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Analyze of key times, places, circumstances, triggers and what de-escalates behavior and document. (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #1's care plan dated 11/15/2021 indicated she has potential to demonstrate physical behaviors related to poor impulse control, and she has had physical altercation with other residents. Interventions included to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Analyze of key times, places, circumstances, triggers and what de-escalates behavior and document. Record review of a face sheet dated 1/9/2024 indicated Resident #2 was a 85-years-old, initially admitted to the facility on [DATE] with readmitted [DATE]. His diagnoses included Type 2 Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), Anemia in Chronic Kidney Disease (your kidneys cannot make enough EPO), Schizophrenia (a serious mental disorder in which people interpret reality abnormally), Dementia (loss of cognitive functioning), anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of a MDS assessment dated [DATE] indicated Resident #2 was able to make himself understood and understand others. He had a BIMS of 03 (severely impaired cognitively). He required supervision for most ADLs . He was frequently incontinent of bowel and occasionally incontinent of bladder. Record review of Resident #2's care plan dated 5/13/2022 indicated Resident #2 demonstrates verbally abusive behaviors towards peers and staff due to Ineffective coping skills, poor impulse control. Resident #2 gets aggravated at times in regard to his finances and in times of not being able to get his way. He is redirected easily. Interventions included to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Analyze of key times, places, circumstances, triggers and what de-escalates behavior and document. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Assess resident's coping skills and support system. Record review of Resident #1's progress note authored by DON indicated that on 8/7/2023 at 4:09 p.m., that the resident presented herself to the DON's office and showed a 2x3cm bruise to the left upper anterior arm, Resident stated that Resident #2 attacked her yesterday (Sunday) because he had the cordless phone and she wanted to use it. Resident was assessed with previous injuries to left hand noted. NP and RP notified. During an interview on 1/3/2024 at 11:09 a.m., Resident #1 said she recalled the incident involving her and Resident #2 that happened on 8/8/2023. Resident #1 said Resident #2 would not let her use the cordless phone to call her family member, he got mad at me and hit me in the arm. Unable to interview Resident #2, he no longer resides in the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/3/2024 at 11:30 a.m., the DON said that she learned about the incident between Resident #1 and Resident #2 when Resident #1 wheeled herself to the DON office door on 8/7/2023 and showed her a bruise on her left upper arm. DON said that she investigated the report and spoke with staff and CN reported that the residents got into a verbal altercation about the use of the cordless phone. DON said no physical altercation was observed by CN, CN intervened and separated the two residents. The CN reported that no visual skin altercations noted at the time, and she separated the two residents. The DON said allegation was reported to the state, facility investigation completed, and AC notified of the allegation. The DON does not recall the time the allegation of abuse for this intake was reported to the state agency but was aware that all allegations of abuse have to be reported to AC or designee immediately and to the state agency no later than 2 hours after the incident occurs or is suspected. During an interview on 1/24/2024 at 3:11p.m., LVN A said she recalls the incident between Resident #1and Resident #2. She said residents got into a verbal altercation regarding the use of the cordless phone. LVN A said that she intervened and separated the two residents, she said that she did not see any physical altercation between the two residents, just verbal. She said she does not recall seeing any marks or abrasions on the residents when she intervened and separated them. She said she has been trained on abuse and neglect and was aware to report any allegations of abuse to the administrator/AC immediately. Record review of TULIP intake for Resident #1 and Resident #2 indicated information date received on 8/8/2023 at 1:23 p.m., read that the allegation of abuse occurred on 8/6/2023 at 12:05 p.m. and the facility first learned of the incident on 8/7/2023 at 10:00a.m. Caller information indicated the reporter of the allegation was the DON. 2. Record review of a face sheet dated 1/9/2024 indicated Resident #3 was 81-years-old, initially admitted to the facility on [DATE] with readmitted [DATE]. His diagnoses included Diabetes (a chronic disease that occurs either when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces), Vitamin Deficiency (is the condition of a long-term lack of a vitamin), Alzheimer's disease (a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment), anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of a MDS assessment dated [DATE] indicated Resident #3 was able to make himself understood and understand others. He had a BIMS of 06 (severely impaired cognitively). He required supervision for most ADLs . He was frequently incontinent of bladder and bowel. Record review of Resident #3's care plan revised on 6/2/2023 indicated Resident #3 has potential to demonstrate verbally abusive behaviors. Interventions included to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Analyze of key times, places, circumstances, triggers and what de-escalates behavior and document. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a face sheet dated 1/9/2024 indicated Resident #4 was a [AGE] year-old, initially admitted to the facility on [DATE] with readmitted [DATE]. His diagnoses included Type 2 Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), Schizophrenia (a serious mental disorder in which people interpret reality abnormally), Dementia (loss of cognitive functioning), anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of a MDS assessment dated [DATE] indicated Resident #4 was able to make himself understood sometimes and understand others sometimes. He had a BIMS of 00 (severely impaired cognitively). He required total care, assistance of 2 or more helpers for most ADLs . He was always incontinent of bowel and bladder. Record review of Resident #4's care plan dated 7/11/2023 indicated Resident #4 has potential to demonstrate physical behaviors due to Poor impulse control. Resident #4 hit another resident with a walker. Interventions included to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Analyze of key times, places, circumstances, triggers and what de-escalates behavior and document. Assess resident's understanding of the situation. Allow time for the resident to express self and feelings towards the situation. Assess resident's coping skills and support system. If the resident has physical behaviors toward another resident, immediately intervene to protect the residents involved and call for assistance. If intervening would be unsafe, call out for staff assistance immediately. Record review of Resident #4's progress note authored by LVN B indicated that on 7/11/2023 at 11:05 a.m., that a CNA reported to LVN B that Resident # 4 was being yelled at by Resident #3, Resident #4 asked Resident #3 to leave him alone and to stop talking to him, Resident #3 continued to yell at Resident #4. CNA intervened and asked both residents to calm down and stop yelling at each other. CNA said they stopped yelling, so she went into hallway to get breakfast trays, CNA returned to area Resident #4 swung walker around CNA and hit Resident #3 in the face, Resident #4 was removed from the area and MD and DON notified. Resident #3 assess by staff with no injuries noted. During an interview on 1/24/2024 at 11:39 a.m., Resident #4 said he does not recall the incident of him hitting Resident #3 and he would never hit or harm anyone. Unable to interview Resident #3, he no longer resides in the facility. During an interview on 1/3/2024 at 11:20 a.m., the Administrator said she was aware of the disagreement between Resident #3 and Resident #4, CNA C was present during the disagreement and reported it to DON and Administrator. She said Resident #3 was upset that Resident #4 did not call for help from him when he fell in the bathroom. Resident #3 repeatedly questioned Resident #4 about why he did not tell him he fell or ask him to help him when he fell , Resident #4 got upset and verbal altercation occurred, and later Resident #4 swung his walker around the CNA and hit Resident #3 in the head. The Administrator said they immediately separated the two residents and moved Resident #4 to another room since they were roommates. Facility staff assessed both residents with no injuries noted. Resident #3 went to a previously scheduled appointment out of the facility. The Administrator said this occurred after breakfast and at supper time they were requesting to sit together at the same table. The Administrator said that she reported the incident to the state within 2 hours of her being notified or made aware of the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of TULIP intake for Resident #3 and Resident #4 indicated information date received on 7/12/2023 at 4:58 p.m., read that the allegation of abuse occurred on 7/11/2023 at 1:45 p.m. and the facility first learned of the incident on 7/12/2023 at 2:00 p.m. Caller information indicates the reporter of the allegation was the Administrator. 3. Record review of a face sheet dated 1/8/2024 indicated Resident #5 was a 88-years-old, initially admitted to the facility on [DATE] with readmitted [DATE]. her diagnoses included chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe), diastolic congestive heart failure (a condition in which the heart's main pumping chamber (left ventricle) becomes stiff), chronic embolism and thrombosis of unspecified vein (a blockage of the pulmonary arteries that occurs when prior clots in these vessels don't dissolve over time despite treatment of an acute pe, or the result of an undetected or untreated acute pe). Record review of a MDS assessment dated [DATE] indicated Resident #5 was able to make herself understood and understand others. She had a BIMS of 15 (cognitively intact). She required total care, assistance of 2 or more helpers for most ADLs . She was always incontinent of bowel and bladder. Record review of Resident #5's care plan dated 12/21/2023 indicated Resident #5 potential/actual impairment to skin integrity r/t fragile skin. Interventions included Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Keep skin clean and dry. Use lotion on dry skin. Record review of Resident #5's progress note authored by LVN D indicated that on 8/26/2023 at 12:40 a.m., that a CNA reported to LVN D that Resident # 5 had a skin tear to back of right lower leg, Resident #5 said that the aide earlier that day that turned her caused the skin tear to her right lower leg. ADON RN notified & RP notified per phone. During an interview on 1/4/2024 at 11:40 a.m., Resident #5 said she does recall the incident of skin tear to right lower leg, she said she had very fragile skin and the staff must be very careful, or they will tear her skin when they turn her. Resident #5 said that CNA D was rough when she turned her and caused the skin tear. She said she told the nursing staff about the incident. During an interview on 1/4/2024 at 11:50 a.m., the Administrator said she was aware of the skin tear to Resident #5 right leg that was caused by CNA D when turning her, she said CNA D was suspended pending the investigation and later terminated. The Administrator said that she reported the incident to the state within 2 hours of her being notified or made aware of the incident. Record review of TULIP intake for Resident #5 indicated information date received on 8/29/2023 at 5:42 p.m. , read that the allegation of abuse occurred on 8/28/2023 at 5:17 p.m. and the facility first learned of the incident on 8/29/2023 at 4:30 p.m. Caller information indicated the reporter of the allegation was the Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Record review of a face sheet dated 1/8/2024 indicated Resident #6 was 55-years-old, initially admitted to the facility on [DATE] with readmitted [DATE]. her diagnoses included Schizophrenia (a serious mental disorder in which people interpret reality abnormally), Dementia (loss of cognitive functioning), anxiety disorder (persistent and excessive worry that interferes with daily activities) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Resident #6 resides in the secure unit at the facility. Record review of a MDS assessment dated [DATE] indicated Resident #6 was able to make herself understood and understand others. She had a BIMS of 05 (severely impaired cognitively). She required supervised and limited assistance for most ADLs . She was always incontinent of bladder and frequently incontinent of bowel. Record review of Resident #6's care plan dated 10/06/2021 indicated Resident #6 resident has impaired cognitive function, dementia, and impaired thought processes. Interventions Engage the resident in simple, structured activities that avoid overly demanding tasks. Keep the resident's, routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion. Record review of Resident #6's progress note authored by LVN F indicated that on 10/31/2023 at 5:18 p.m., that she heard a sound of a hit while resident was sitting down, and peer resident (Resident #7) was standing over this resident, nurse intervened resident from hitting peer resident with her fist and asked her to calm down, which she did and stated that peer resident was all over her, DON, NP was notified, new order is to keep resident separate. RP notified. Record review of a face sheet dated 1/8/2024 indicated Resident #7 was 86-years-old, initially admitted to the facility on [DATE] with readmitted [DATE]. Her diagnoses included Dementia (loss of cognitive functioning), and anxiety disorder (persistent and excessive worry that interferes with daily activities). Resident #7 resided in the secure unit at the facility. Record review of a MDS assessment dated [DATE] indicated Resident #7 was able to make herself understood and usually understand others. She had a BIMS of 00 (severely impaired cognitively). She required supervised and moderate assistance for most ADLs . She was always incontinent of bladder and bowel. Record review of Resident #7's care plan dated 09/25/2023 indicated Resident #7 has potential to demonstrate verbally abusive behaviors. Interventions Assess and anticipate resident's needs: food, thirst. toileting needs, comfort level, body positioning, pain etc. Give the resident as many choices as possible about care and activities. Notify the charge nurse of any abusive behaviors. Record review of Resident #7's care plan dated 10/10/2023 indicated Resident #7 has potential to demonstrate physical behaviors due to Anger and Poor impulse control. Interventions included to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. Analyze of key times, places, circumstances, triggers and what de-escalates behavior and document. Assess and address for contributing sensory deficits. Notify the charge nurse of any physically abusive behaviors. Psychiatric/Psychogeriatric consult as indicated. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #7's progress note authored by LVN F indicated that on 10/31/2023 at 4:58 p.m., that she was sitting in the nurses' station and heard a slap sound. Observed resident sitting in front of the TV Room door with Resident #7 standing with walker in front of her, Resident #6 had her fist up in the air swinging it toward this Resident #7, LVN F intervened and redirected resident from swinging fist at this Resident #7. During an interview on 1/4/2024 at 1:40 p.m., Resident #6 said she does not recall the incident and denies any abuse or neglect from facility staff. During an interview on 1/4/2024 at 1:45 p.m., Resident #7 was unable to answer questions appropriately. During an interview on 1/4/2024 at 11:45 a.m., the Administrator said she became aware of the allegation of abuse on Resident #6 and Resident #7 when she was performing quarterly audits of the event notes. She said she was not aware of this incident until then and reported it to the state agency as soon as she realized it was a reportable incident. Record review of TULIP intake for Resident #6 and Resident #7 indicated information date received on 12/12/2023 at 7:05 p.m., read that the allegation of abuse occurred on 10/31/2023 at 3:45 p.m. and the facility first learned of the incident on 12/12/2023 at 4:45 p.m. Caller information indicates the reporter of the allegation was the Administrator. During an interview on 1/4/2024 at 2:15 p.m. with LVN G, she said she worked in the secure unit mostly and has been employed with facility over 5 years. She said we watch the residents back her closely but if an allegation of abuse occurs that we report it to the administrator or designee immediately. During an interview on 1/8/2024 at 1:15 p.m. with CNA H, she said she works the secure unit mostly, been employed with facility over 3 years, she said if allegation of abuse or neglect occurred that she would report it to the charge nurse. 5. During observation tour on 1/24/2024 at 3:00 p.m. of the secure unit, revealed Resident # 14 with bruises to face, right forehead and left eye. During interview on 1/24/2024 at 3:05 p.m., LVN G said that Resident #14 had a fall on 1/15/2024 causing the bruises to face area, was sent to ER and also had fracture rib. LVN G said that Resident # 14 has a history of falls. Record review of a face sheet dated 1/24/2024 indicated Resident #14 was 76-years-old, initially admitted to the facility on [DATE]. Her diagnoses included Schizophrenia (a serious mental disorder in which people interpret reality abnormally), hypertension (a condition in which the force of the blood against the artery walls is too high), Alzheimer's disease (a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment). Resident #14 resided in the secure unit at the facility, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a MDS assessment dated [DATE] indicated Resident #14 was able to make herself understood and usually understand others. She had a BIMS of 03 (severely impaired cognitively). She required supervision assistance for most ADLs . She was always incontinent of bladder and frequently incontinent bowel. Record review of Resident #14's care plan dated 1/15/2024 indicated Resident # 14 was risk for further falls r/t Confusion and poor impulse control. Resident # 14 has poor safety awareness. Resident # 14 sustained sixth rib fracture to her left side. Interventions Anticipate and meet the resident's needs. Encourage the resident to participate in activities that promote exercise, physical activity for strengthening and improved mobility. Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c. Pt evaluate and treat as ordered or PRN. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. The resident needs a safe environment with even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night; handrails on walls, personal items within reach. The resident needs activities that minimize the potential for falls while providing diversion and distraction. Record review of Resident #14's progress note authored by LVN A indicated that on 1/15/2024 at 12:40 a.m. , Resident was in room and staff heard a loud noise, CNA and CN to room. Resident had been up and moving around and fell in room, she had diaper around her ankles torn off on one side. resident was lying on floor by bathroom door on stomach. She was crying out and moaning, attempting to get off floor by self. V/S were taken, and full skin assessment was done, found delayed bruising on hip from previous fall, resident was complaining of pain below L Breast and holding her chest and rib area. She was letting out yell in pain when palpated area, spoke with RN from hospice and she stated to send resident out to ER for evaluation and treatment. RP notified and stated to send resident to local ER as needed. Notified DON, Neuros started until EMS will come and monitor resident. Record review of Resident #14's progress note authored by LVN A indicated that on 1/15/2024 at 5:29 a.m., resident returned to facility from local ER with diagnosis of a left 6th rib fracture and new orders for Tylenol 650mg 1 tab by mouth as needed every 4 hours for pain and resident to return to ER if any breath difficulties occur. Vital signs stable and no complaints of pain or discomfort. Resident to be monitored for any changes. During an interview on 1/24/2024 at 9:45 a.m., Resident #14 just rambled and mumbled when asked questions. Unable to verbalize incident of falls and/or injuries. During an interview on 1/24/2024 at 3:11 p.m., LVN A recalled the incident with Resident # 14 on 1/15/2024, said she and the CNA was in TV room with another resident that was actively dying, heard a noise in Resident # 14's room, so she and the CNA went to the room. Resident #14 was found on floor near the bathroom on her stomach with her diaper around her ankle, she said that resident was not cognitively intact, so she was not able to tell staff what had happened. LVN A said she complained of pain to breast/chest area, and she was sent to ER for evaluation and treatment. LVN A said this unwitnessed fall with injury was reported to DON on 1/15/2024. During an interview on 1/24/2024 at 3:45 pm, the DON said that she was aware of Resident # 14's unwitnessed fall with injury but did not feel the incident meet the requirement to be reported to the state. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of TULIP 1/24/2024 at 4:00 p.m. revealed no intake for Resident #14's unwitnessed fall with injury. During an interview on 1/4/2024 at 9:15 a.m., the Administrator said the expectations was for the facility staff to report all suspicions or allegations of abuse immediately to her, as the abuse coordinator. She said if she was not available, staff should report to the supervisor in charge. She said the timeframe for reporting allegations of abuse to the state agency was to report within 2 hours of the allegation. The administrator said she or the designee should have reported allegations of abuse to the state agency within 2 hours of the allegation. Record review of the facility's Abuse and Neglect policy dated 3/29/18 indicated . When a suspected abused, neglected, exploited, mistreated or potential victim of misappropriation of property comes to the attention of any employee, that employee will make an immediate verbal report to the Abuse Preventionist or designee. If the discovery occurs outside of normal business hours, the Abuse Preventionist and/or designee will be called If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Nursing and Rehabilitation	1175 Denton Dr Beaumont, TX 77707

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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 - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47879 Based on observation, interview, and record review, the facility failed to ensure an effective infection prevention and control program to prevent the development and transmission of communicable diseases was implemented by the facility for 8 of 8 residents (Residents #8, #9, #10, #11, #12, #13, #17, and #18) and 13 of 13 staff (CNA J, MA K, CNA N, HSK O, LVN X, LDY P, CNA Q, CNA R, CNA S, CNA T, LVN U, CNA V, and LVN W) in the facility reviewed for infection control practices and transmission-based precautions. The facility failed to ensure facility staff (CNA J, MA K, CNA N and HSK O) wore appropriate PPE when entering COVID-19 (infectious disease caused by the SARS virus) positive residents' rooms. (Residents #8, #9 #10, #11, #12, and #13). The facility failed to ensure staff was knowledgeable on current COVID-19 (infectious disease caused by the SARS virus) protocols and interventions. The facility staff failed to follow facility infection prevention policies to prevent the spread of infections. Staff (LVN X, LDY P, CNA Q, CNA R, CNA S, CNA T, LVN U, CNA V, and LVN W) were not being tested routinely after a staff tested positive for COVID-19 (infectious disease caused by the SARS virus) on [DATE]. During the ongoing outbreak, staff were observed working with positive COVID-19 residents and negative residents. Residents # 8, #17, and #18 expired at the facility after testing positive. The facility failed to ensure facility staff had readily available access to appropriate PPE supplies in 2 of the 6 isolation carts on Hall 200. An IJ was identified on [DATE]. The IJ template was provided to the facility on [DATE] at 1:50 p.m. While the IJ was removed on [DATE], the facility remained out of compliance at a scope of widespread and a severity level of no actual harm with the potential for more than minimal harm because all staff had not been trained on [DATE]. These failures could place residents at an increased risk for serious complications from a communicable disease that could diminish the resident's quality of life or possible death. The findings included: Record review of the Covid Positive Resident Log dated [DATE] indicated on [DATE] the first COVID-19 positive case was from a staff who worked the secured unit. Since the initial outbreak, 32 residents have tested positive for COVID. Three residents expired during their 14-day quarantine. During an interview on [DATE] at 8:30 a.m., the Administrator said facility census was 50 with 10 COVID-19 positive residents and with 3 staff COVID-19 positive. During an interview on [DATE] at 1:30 p.m., the DON said facility census was 46 with 11 new COVID-19 positive residents and with 5 new staff COVID-19 positive. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Record review of a face sheet dated [DATE] indicated Resident #8 was a [AGE] year-old male, initially admitted to the facility on [DATE] with readmitted [DATE].His diagnoses included dementia (loss of cognitive functioning), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), end stage renal disease, and COVID-19. Record review of Resident #8's MDS dated [DATE] revealed he had a BIMS score of 3 which indicated he was severely impaired cognitively. He usually could make self-understood and usually understood others. He required moderate assistance in performing most activities of daily living. He was always incontinent of bowel and bladder. Record review of Resident #8's Care plan dated [DATE] indicated he needs hemodialysis r/t renal failure, Resident goes to dialysis 3 x week with goals that resident will have immediate intervention should any s/s of complications from dialysis occur through the review period. had manipulative behavior with history of accusing people of slapping her/physically mishandling her with a goal that resident would have less than 1 episode of accusatory behavior for the next 90 days. Care plan dated [DATE] indicates he requires isolation precautions r/t active Covid infection with a goal that resident's risk for complications r/t active COVID-19 will be minimized through next review date. Record review of Resident #8's progress notes on [DATE] at 12:17 p.m. authored by RN L indicated Resident #8 tested positive for COVID-19 on [DATE]. Resident expired on [DATE] (5 days after testing positive for COVID-19). Record review of the order summary report, dated [DATE], indicated Resident #8 had an order, which started on [DATE], for Aerosol precautions, every shift related to COVID-19 for 10 days. Record review of a face sheet dated [DATE] indicated Resident #9 was a [AGE] year-old male, initially admitted to the facility on [DATE] with readmitted [DATE].His diagnoses included dementia (loss of cognitive functioning), type 2 diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), and COVID-19 (infectious disease caused by the SARS virus). Record review of Resident #9's MDS dated [DATE] revealed he had a BIMS score of 15 which indicated he was cognitively intact. He is able to make needs known and understands others. He required supervision in performing most activities of daily living. He was continent of bowel and bladder. Record review of Resident #9's Care plan dated [DATE] indicates he requires isolation precautions r/t active Covid infection with a goal that resident's risk for complications r/t active COVID-19 will be minimized through next review date. Record review of Resident #9's progress notes on [DATE] at 11:12 a.m. authored by RN L indicated Resident #9 tested positive for COVID-19 on [DATE]. Record review of the order summary report, indicated Resident #9 had an order, which started on [DATE], for Aerosol precautions, every shift related to COVID-19 for 10 days. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an observation on [DATE] at 12:15 p.m., CNA J entered Resident #8 and Resident #9's room on Hall 200 to provide them with lunch trays. CNA J was wearing a N-95 mask and gloves. There was a sign on the door that stated, Droplet Precautions and listed the required PPE needed to be worn in the room, which included an N-95 mask, a face shield or goggles, an isolation gown, and gloves. CNA J remained in the room for approximately 5 minutes assisting and preparing lunch tray. Upon exiting the room, CNA J removed her gloves, sanitized her hands, and walked down the hallway toward the lunch tray cart wearing the same N-95 mask. During observation [DATE] @ 12:30 p.m., insolation carts outside of room [ROOM NUMBER] and room [ROOM NUMBER] had boxes of gloves, boxes of surgical mask and N-95 mask and face shields, no gowns noted in these 2 isolation carts. During an interview on [DATE] at 1:35 p.m., CNA J said she did not wear PPE (gown and face shield) into Resident #8 and Resident #9's room because the isolation supply cart outside of the residents' room did not have any gowns or face shields available. CNA J said, I was trying to get the residents lunch served, so I went into room without gown and face shield. CNA J said, I know I should have put a gown and face shield on, but it was not readily available in the isolation cart outside door, which happens sometimes, and we do not have access to supplies to restock isolation carts. CNA J said she had received training on infection control, COVID-19 protocol, and PPE application courses via computerized online training assigned to her by facility within the last month. During an interview on [DATE] at 2:15 p.m., LVN G said Resident #8 was asymptomatic when he tested positive for COVID-19. LVN G said Resident #8 was attending his dialysis treatments and was not experiencing any severe symptoms with his COVID-19. LVN G said resident was cognitive and able to report any illness or concerns to the facility staff. LVN G said she was the nurse providing care to the resident the day he passed on [DATE], she said she had visited with him several times throughout the shift, and he had no complaints. She said she was notified by CNA that resident was not responding to verbal or tactile stimulus, when she entered the room, resident was unresponsive, no respirations, no pulse and body cool to the touch, appeared he had died in his sleep. LVN G said she provided care to positive and non-positive COVID-19 residents with her assigned residents. LVN G said that the electronic medical record identified residents positive for COVID-19, notification during shift change of all positive COVID-19 residents, signage on resident's room door identifies droplet precautions and COVID-19 precautions to follow. LVN G said that full PPE (gown, gloves, face mask and N-95 should be applied prior to entering COVID-19 positive residents' rooms, worn while providing care to resident and removed prior to exiting room and placed in red bag in room for disposal. LVN G said PPE was available in isolation cart when needed. LVN G said she had received training on COVID-19 and PPE precautions in the last month. 2. Record review of a face sheet date [DATE] indicated Resident #18 was a [AGE] year-old, initially admitted to the facility on [DATE] with readmitted [DATE]. Her diagnoses included dementia (loss of cognitive functioning), urinary tract infection, gastro-esophageal reflux disease without esophagitis (stomach contents leak backward from the stomach into the esophagus (food pipe), COVID-19, and history of COVID-19, history of cancer of the rectum and stomach and anxiety disorder (persistent and excessive worry that interferes with daily activities). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of Resident #18's MDS dated [DATE] revealed she had a BIMS score of 0 which indicated he was severely impaired cognitively. She had cognitive loss/dementia with diagnosis of Alzheimer's Disease. She was noted to have disorganized thinking. She required total assistance in performing most activities of daily living. She was always incontinent of bowel and bladder. Record review of Resident #18's Care plan dated [DATE] indicates he requires isolation precautions r/t active Covid infection with a goal that resident's risk for complications r/t active COVID-19 will be minimized through next review date. Record review of Resident #18's progress note dated [DATE] authored by LVN G indicated resident was diagnosed with a urinary tract infection and started on antibiotic treatment ordered by hospice services. Record review of Resident #18's progress notes dated [DATE] authored by DON indicated resident tested positive for COVID-19 during routine testing for exposure. Resident #18 received antibiotic treatment for COVID-19. Record review of Resident #18's progress note dated [DATE] authored by LVN DD indicates resident was admitted to new hospice for a diagnosis of senile degeneration of the brain. Record review of Resident #18's Covid Assessment date [DATE] authored by LVN G indicates that covid finding include a productive and non-productive Cough, with no new or worsen symptoms, regular respirations, and clear breath sounds. Interventions include monitoring/assessing every shift for Covid concerns. Indicates resident remain on droplet precautions and resides in room by herself. Record review Resident #18's of the progress note dated [DATE] (13 days after testing positive for COVID-19) authored by LVN BB indicated Resident #18 was provided care multiple times throughout the shift with no discomfort or complaints. The CNA entered the resident's room around 2:00 a.m. to find the resident unresponsive, no respirations or heart rate so CPR was initiated. EMS arrived and continued CPR and then discontinued CPR. The hospice nurse was notified, and hospice arrived to pronounce the resident had expired. 3. Record review of a face sheet dated [DATE] indicated Resident #17 was a [AGE] year-old female, initially admitted to the facility on [DATE] with readmitted [DATE]. Her diagnoses included personal history of cancer of the rectum, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (persistent and excessive worry that interferes with daily activities). Record review of Resident #17's MDS dated [DATE] revealed she had a BIMS score of 0 which indicated she was severely impaired cognitively. She was noted to have disorganized thinking. She could make her needs known and understands other. She required minimal assistance in performing most activities of daily living. She was occasionally incontinent of bladder and continent of bowel. Record review of Resident #17's Care plan dated [DATE] indicates he requires isolation precautions r/t active Covid infection with a goal that resident's risk for complications r/t active COVID-19 will be minimized through next review date. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of Resident #17's progress note dated [DATE] authored by DON indicated resident tested positive for COVID-19 during exposure testing, facility staff (LVN A and CNA CC) working the secure unit tested positive for COVID-19 on [DATE]. Resident asymptomatic at time of testing. Resident expired on [DATE] (14 days after testing positive for COVID-19). Record review of Resident #17's Covid Assessment date [DATE] authored by LVN A indicates under covid finding include no cough or covid findings, with no new or worsen symptoms, regular respirations, and clear breath sounds. Interventions include monitoring/assessing every shift for Covid concerns. Indicates resident remain on droplet precautions and resides in room by herself. During an interview on [DATE] at 2:15 p.m., LVN G said Resident #17 was asymptomatic with her COVID-19 positive test results. LVN G said Resident #17 had behavioral episodes including yelling and screaming out. LVN G said Resident #17 resided on the secure unit because of her cognitive state. LVN G said she works with positive and negative residents. 4. Record review of a face sheet dated [DATE] indicated Resident #10 was a [AGE] year-old female, initially admitted to the facility on [DATE]. Her diagnoses included CVA/Stroke (occurs when something blocks blood supply to part of the brain or when a blood vessel in the brain burst), Diabetes (a chronic condition that affects the way the body processes blood sugar) and depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Record review of Resident #10's MDS dated [DATE] revealed she had a BIMS score of 15 which indicated she was cognitively intact. She could make her needs known and understands other. She required total assistance in performing most activities of daily living. She was always incontinent of bladder and bowel. Record review of Resident #10's Care plan dated [DATE] indicates he requires isolation precautions r/t active Covid infection with a goal that resident's risk for complications r/t active COVID-19 will be minimized through next review date. Record review of Resident #10's progress note dated [DATE] authored by LVN A resident c/o stuffy nose, headache, and sore throat. The resident was tested for Covid and was positive for COVID-19. Record review of the order summary report, dated [DATE], indicated Resident #10 had an order, which started on [DATE], for Aerosol precautions, every shift related to COVID-19 for 10 days. During an observation on [DATE] at 12:18 p.m., MA K entered Resident #10's room (resided on Hall 200) to provide her with a lunch tray. MA K was wearing a N-95 mask and gloves. There was a sign on the door that stated, Droplet Precautions and listed the required PPE needed to be worn in the room, which included an N-95 mask, a face shield or goggles, an isolation gown, and gloves. MA K remained in the room for approximately 5 minutes assisting and preparing lunch tray. Upon exiting the room, MA K, removed her gloves, sanitized her hands, and walked down the hallway toward the lunch tray cart wearing the same N-95 mask. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 1:50 p.m., MA K said she did not wear PPE (gown and face shield) into Resident #10's room because the isolation supply cart outside of the residents' room did not have any gowns or face shields. MA K said, I was trying to help the I get the lunch tray served. MA K said, I know I should have but a gown and face shield on, but it was not readily available in the isolation cart outside of the resident's room. MA K said she should have gone to central supply closet and got gowns or contacted central supply personnel regarding isolation cart needing to be restocked. MA K said she had received training on infection control, COVID-19 protocol, and PPE application courses via computerized online training assigned to her by facility within the last month. During an interview on [DATE] at 12:20 p.m., RN L said all staff was instructed to wear appropriate PPE when entering positive COVID-19 residents' room. RN L said the required PPE for entering a COVID-19 positive room was an isolation gown, gloves, an N-95 mask, and a face shield. RN L said it was important to wear the recommended PPE to protect other residents and staff. RN L said, I have spoken with CNA J and MA K and reeducated them on PPE when entering positive COVID-19 residents' rooms. During observation [DATE] @ 12:30 p.m., insolation carts outside of room [ROOM NUMBER] and room [ROOM NUMBER] had boxes of gloves, boxes of surgical mask and N-95 mask and face shields, no gowns noted in these 2 isolation carts. During an observation and interview on [DATE] at 9:00 am, CS M said she restocked the isolation carts twice a day (usually morning and evening prior to leaving) and more frequently if notified. CS M showed the location of the PPE supplies in the supply closet on each hall with PPE supplies (gowns, gloves, N-95 mask, and face shields) and a large supply room that had additional PPE supplies. CS M said nursing staff had access to the supply closets on the hall and she and management held the key to the large supply room. CS M said she was not aware of any needed PPE supplies and if the isolation carts were low, staff could notify her or collect the supplies from the supply closet on the halls. 5. Record review of a face sheet dated [DATE] indicated Resident #11 was an [AGE] year-old male, initially admitted to the facility on [DATE] and readmitted on [DATE]. His Senile Degeneration of the Brain (is the mental deterioration (loss of intellectual ability) that is associated with or the characteristics of old age), Covid (infectious disease caused by the SARS virus) and Pressure ulcer of sacral (caused by something putting pressure on or rubbing your skin). Record review of Resident #11's MDS dated [DATE] revealed he had a BIMS score of 00 which indicated he was severely impaired cognitively. He could usually make his needs known and usually understands other. He required total assistance in performing most activities of daily living. He was foley catheter for urinary incontinence and always incontinent of bowel. Record review of Resident #11's Care plan dated [DATE] indicates he requires isolation precautions r/t active Covid infection with a goal that resident's risk for complications r/t active COVID-19 will be minimized through next review date. Record review of Resident #11's progress note dated [DATE] authored by DON, resident was tested for Covid per facility protocol and was positive for COVID-19. Resident placed in Aerosol Precautions. Record review of the order summary report, dated [DATE], indicated Resident #11 had an order, which started on [DATE], for Aerosol precautions, every shift related to COVID-19 for 10 days. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Record review of a face sheet dated [DATE] indicated Resident #12 was a [AGE] year-old male, initially admitted to the facility on [DATE] and readmitted on [DATE]. His diagnosis is included Type 2 Diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), Esophagitis (inflammation of the esophagus), and Covid (infectious disease caused by the SARS virus). Record review of Resident #12's MDS dated [DATE] revealed she had a BIMS score of 00 which indicated he was severely impaired cognitively. He could sometimes make his needs known and sometimes understands other. He required supervision assistance in performing most activities of daily living. He was foley catheter for urinary incontinence and always incontinent of bowel. Record review of Resident #12's Care plan dated [DATE] indicates he requires isolation precautions r/t active Covid infection with a goal that resident's risk for complications r/t active COVID-19 will be minimized through next review date. Record review of Resident #12's progress note dated [DATE] authored by DON, resident was tested for Covid per facility protocol and was positive for COVID-19. Resident placed in Aerosol Precautions. Record review of the order summary report, dated [DATE], indicated Resident #12 had an order, which started on [DATE], for Aerosol precautions, every shift related to COVID-19 for 10 days. During an observation and interview on [DATE] at 9:00 a.m., CNA N entered to provide care for Resident #11 and Resident #12 who resided on Hall 100. CNA N was wearing a N-95 mask and gloves. There was a sign on the resident's door that stated, Droplet Precautions and listed the required PPE needed to be worn in the room, which included an N-95 mask, a face shield or goggles, an isolation gown, and gloves. CNA N remained in the room for approximately 6 minutes providing care to residents. Upon exiting the residents' room, CNA N removed her gloves and sanitized her hands walked down the hallway past other residents and visitors wearing same N-95 mask. CNA N said Residents #11 and #12 were no longer under isolation precautions and they forgot to remove the isolation sign. During interview on [DATE] at 9:15 a.m. the DON said Resident #11 and Resident #12 were currently under droplet isolation precautions due to both residents' testing positive for COVID-19 on [DATE]. She said the residents' isolation was due to end on [DATE]. The DON said she informed CNA N that Residents #11 and #12 remained under droplet isolations and she should be wearing her PPE while providing resident care. The DON said she verbally instructed CNA N just now about properly applying PPE, droplet precautions protocols and facility residents who currently required droplet precautions. 6. Record review of a face sheet dated [DATE] indicated Resident #13 was a [AGE] year-old female, initially admitted to the facility on [DATE]. Her diagnosis is included schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), Dementia (loss of cognitive functioning), and Covid (infectious disease caused by the SARS virus). Record review of Resident #13's MDS dated [DATE] revealed she had a BIMS score of 15 which indicated she was cognitively intact. She could make her needs known and understands other. She required limited assistance in performing most activities of daily living. She was always continent of bowel and bladder. (continued on next page)

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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 - Many	Record review of Resident #13's Care plan dated [DATE] indicates he requires isolation precautions r/t active Covid infection with a goal that resident's risk for complications r/t active COVID-19 will be minimized through next review date. Record review of Resident #13's progress note dated [DATE] authored by DON, resident was tested for Covid per facility protocol and was positive for COVID-19. Resident placed in Aerosol Precautions. Record review of the order summary report, dated [DATE], indicated Resident #13 had an order, which started on [DATE], for Aerosol precautions, every shift related to COVID-19 for 10 days. During an observation and interview on [DATE] at 9:45 a.m., HSK O was standing outside of Resident #13's room on Hall 100 in full PPE (gown, gloves, N-95 mask, face shield), with a trash can sitting on top of the housekeeping cart while HSK O replaced the trash liner. There was a sign on Resident #13's door that stated, Droplet Precautions and listed the required PPE needed to be worn in the room, which included an N-95 mask, a face shield or goggles, an isolation gown, and gloves. HSK O said she had just finished cleaning Resident #13's room and she forgot a trash liner on the cart, so I came back out to the cart to get trash liner for the resident's room trash can. HSK O identified the trash can on her housekeepers' cart as the trash can she brought out of Resident #13's room. HSK O said she had just started working at the facility the previous weekend but had been trained on droplet precautions and wearing PPE. When asked if she was supposed to wear the PPE out of the residents' room that was under droplet precautions, she said that during her observation training, other housekeeping staff had done it, so she thought it was OK. During interview on [DATE] at 9:55 a.m., RN L said Resident #13 remained under droplet isolation precautions due the resident testing positive for COVID-19 on [DATE]. RN L said she informed HSK O that Resident # 13 remained under droplet isolations, and she should be wearing her PPE while in the resident's room, and PPE should be removed prior to exiting the resident's room. 7. During an interview on [DATE] at 11:45 a.m., LVN X said she was not tested routinely by facility since outbreak on [DATE]. LVN X said she was tested for COVID-19 by the facility on [DATE] because she became symptomatic (cough and congestion) and tested positive. LVN X said she was sent home and quarantined for 7 days with 2 negative tests 48 hours apart before returning to work. LVN X said she has received training on infection control, COVID-19 precautions/protocol and PPE application. LVN X said that she applied PPE prior to entering COVID-19 positive residents' rooms. LVN X said staff were notified in the EMR on the communication board when residents were positive for COVID-19 and as a charge nurse she notified her staff when residents tested positive for COVID-19 and who required isolation precautions. During an interview on [DATE] at 12:30 p.m., LDY P said he was working in the laundry department today due to the laundry staff being out with COVID-19. LDY P said that if he was symptomatic, the facility would test him. LDY P said he wore full PPE (gloves, gowns, N-95 mask, face shield) while handling the dirty laundry as he was told to treat all dirty laundry as contaminated and to use PPE when handling. He said he received computer-based training on infection control, COVID-19 protocol, and PPE use at the end of [DATE]. LDY P said he had not been tested for COVID-19 by the facility in over a week or maybe 2. LDY P said he did have contact with residents at various times while out in the halls and when he delivered laundry to the resident's rooms. He said he applied full PPE to deliver laundry to residents on isolation. He said he also worked in the housekeeping department and cleaned residents' rooms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675620	A. Building B. Wing	01/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beaumont Nursing and Rehabilitation	1175 Denton Dr Beaumont, TX 77707

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] at 1:45 p.m., CNA J said she had not been tested by the facility for COVID-19. CNA J said, if I was symptomatic, I would be tested . Do I need to go get tested ? CNA J said she worked with both non-positive and positive COVID-19 residents. During an interview on [DATE] at 1:50 p.m., CNA Q said she had not been tested by the facility for COVID-19. CNA Q said she had not been having symptoms of COVID-19 and the facility was only testing staff who had symptoms. CNA Q acknowledged that residents/staff could be asymptomatic and have COVID-19. CNA Q said she worked with both non-positive and positive COVID-19 residents. During an interview on [DATE] at 2:15 p.m., CNA R said she had not been tested by the facility for COVID-19. CNA R said she had not been having symptoms of COVID-19, so she had not been tested . CNA R acknowledged that residents/staff could be asymptomatic and have COVID-19. CNA R questioned if she should be tested for COVID-19. CNA R said it had been over 2 weeks since she was last tested by the facility for COVID-19. CNA R said she worked with both non-positive and positive COVID-19 residents. During an interview on [DATE] at 2:30 p.m., CNA S said he had not been tested by the facility for COVID-19. CNA S said she had not been having symptoms of COVID-19, so she had not been tested . CNA S acknowledged that residents/staff could be asymptomatic and have COVID-19. CNA S questioned if she should be tested for COVID-19. CNA S said it had been over 2 weeks since she was last tested by the facility for COVID-19. CNA S said she worked with both non-positive and positive COVID-19 residents. During an interview on [DATE] at 2:35 p.m., CNA T said she had not been tested by the facility for COVID-19. CNA T said she had not been having symptoms of COVID-19, so she had not been tested . CNA T acknowledged that residents/staff could be asymptomatic and have COVID-19. CNA T questioned if she should be tested for COVID-19. CNA T said it had been over 2 weeks since she was last tested by the facility for COVID-19. CNA S said she worked with both non-positive and positive COVID-19 residents. During an interview on [DATE] at 2:41 p.m., LVN U said she had not been tested by the facility for COVID-19. LVN U said she had only been employed for a few weeks with facility. She said she received training on COVID-19, infection control and PPE application/use during orientation. She said she had not been tested for COVID-19 since she started working at the facility. LVN U said she wore a surgical mask when caring for non-positive COVID-19 residents and N-95 and full PPE while caring for positive COVID-19 residents. LVN U said she was assigned to work with both non-positive and positive COVID-19 residents. During an interview on [DATE] at 2:45 p.m., CNA V said she had not been tested by the facility for COVID-19. CNA V said she had not been having symptoms of COVID-19, so she had not been tested . CNA V said it had been over 1 week since she was last tested by the facility for COVID-19. CNA V said she worked with both non-positive and positive COVID-19 residents. CNA V said she had received training on COVID-19 protocols in the last month. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on [DATE] beginning at 3:21 p.m., LVN W said she had not been tested by the facility for COVID-19. LVN W said she tested herself at home frequently before entering the facility because of her own medical concerns. LVN W said she received computer-based training on COVID-19, infection control and PPE application/use from facility in the last month. LVN W said she wore an N-95 mask when caring for non-positive COVID-19 residents and wore the full PPE (N-95 mask, gown, gloves, face shield) while caring for positive COVID-19 residents. LVN W said she was assigned to work with both non-positive and positive COVID-19 residents. During an interview on [DATE] at 3:30 p.m., the DON said the facility was only testing symptomatic staff for COVID-19. The DON was unable to provide a log of facility staff's COVID-19 test results. The DON said she thought the policy indicated only to test staff for COVID-19 if they were experiencing symptoms. The DON said nursing staff were working with positive and non-positive residents. The DON said they were following the Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic from the CDC for guidance for COVID-19 protocol. During an interview on [DATE] at 3:35 p.m., the DON said she was the infection preventionist for the facility and responsible for overseeing infection control, she said that the health department had been notified on the outbreak, but no guidance provided. She said prevention measures initiated by facility included handwashing and standard precautions training, signs for staff and visitors related to infection control, COVID, and PPE