STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455930	A. Building B. Wing	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Ridge Rehabilitation and Healthcare Center	1700 N Washington Pilot Point, TX 76258

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy 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** 26269 Based on observations, interviews and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infection for 4 (Resident #2, #3, #6 and #7) of 9 residents reviewed for infection control. The facility failed to cohort residents based upon COVID-19 status. Resident #6 and #7 contracted COVID-19 after being cohorted with roommates who were COVID-19 positive. Resident #7 expired 6 days after contracting COVID-19. Residents #2 and #3 were negative for COVID-19 but their roommates, Residents #1 and #4, were positive. An Immediate Jeopardy was identified on [DATE] at 2:12 PM. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that was not Immediate Jeopardy and a scope of pattern because the facility was still monitoring the effectiveness of their Plan of Removal. These failures placed residents, who resided on the Memory Care Unit, at risk of exposure to COVID-19, which could result in serious illness, hospitalization , and/or death. Findings included: In an interview on [DATE] at 9:33 AM, the DON, who was the Infection Control Preventionist, said the facility had a COVID-19 outbreak. She said the Memory Care Unit had a census of 18 and 15 were currently positive for COVID-19. She said the three residents on the Memory Care Unit that were not positive, Residents #2, #3, and #10, were encouraged to just stay in their rooms. Record Review of the facility's COVID-19 Outbreak Tracking dated [DATE], indicated the first COVID-19 positive case on the Memory Care Unit was on [DATE], Resident #9. On [DATE], Resident #4 tested positive. On [DATE], Resident #8 tested positive. On [DATE], Resident #5 tested positive. On [DATE], Resident #6 tested positive. Record Review of the facility census dated [DATE] indicated, the following COVID-19 negative residents resided on the Memory Care Unit, Resident #10 was in a private room, Residents #2 and #3 resided in the rooms with COVID-19 positive residents, Residents #1 and #4. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Cedar Ridge Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 N Washington Pilot Point, TX 76258	

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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	Record Review of Resident #2's Admission Record dated [DATE] indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with a diagnosis of dementia. She was roommates with Resident #4. Record Review of the facility's COVID-19 Outbreak Tracking dated [DATE], indicated Resident #2's roommate, Resident #4, tested positive for COVID-19 on [DATE]. Resident #2 was negative, as of [DATE]. Record Review of Resident #2's census record from [DATE] - [DATE] indicated Resident #2 remained roommates with Resident #4. Record Review of Resident #3's Admission Record dated [DATE] indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease. She was roommates with Resident #1. Record Review of the facility's COVID-19 Outbreak Tracking dated [DATE], indicated Resident #3's roommate, Resident #1, tested positive for COVID-19 on [DATE]. Resident #3 was negative, as of [DATE]. In an observation and interview on [DATE] at 10:26 AM, on the Memory Care Unit, revealed Resident #2, who the facility identified as COVID-19 negative, was sitting in her wheelchair at the nurse's station. She wore a face mask. Other positive residents on the unit wandered around the nurse's station and hall without masks on. LVN A said Resident #2 was COVID-19 negative but could not be moved off the unit because she was a flight risk. She said Resident #2's roommate, Resident #4, was COVID-19 positive, and they resided in the same room. She said Resident #10 was negative but resided in a private room and did not come out of her room. She said Resident #3 was COVID-19 negative but resided in a room with a COVID-19 positive roommate, Resident #1. She said the staff were doing the best they could to try to keep residents separated and to encourage them to wear masks, but it was difficult on the unit with confused and wandering residents. She said ideally the residents, who were negative, would be kept apart from positive residents for infection control purposes. She said the first case of COVID-19 on the unit was Resident #9 on [DATE]. She said all the current residents were doing well and recovering. She said Resident #7 expired after contracting COVID-19, he did have a COVID-19 positive roommate, Resident #8, but was on hospice related his diagnoses of skin cancer and dementia, at the time of his death. She said Resident #7 was declining prior to contracting COVID-19 but the infection may have contributed to his passing because he stopped eating and drinking. Record Review of Resident #7's Admission Record dated [DATE] indicated the [AGE] year-old male resident was admitted to the facility on [DATE] with diagnoses which included, Alzheimer's disease and basal cell skin cancer. He was diagnosed with COVID-19 on [DATE] and expired, in the facility, on [DATE] (6 days later). His roommate was Resident #8. Record Review of Resident #7's Nurse's Note on [DATE] at 1:28 PM indicated a COVID test was completed, and the results were negative. Record Review of Resident #7's census record from [DATE] - [DATE] indicated he remained roommates with Resident #8, until Resident #7 expired on [DATE]. Record Review of Resident #7's Nurses' Note dated [DATE] 4:23 PM, the A COVID-19 test was done, the resident was positive. His responsible party was notified. (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 #7's Nurse's Note dated [DATE] at 9:51 PM indicated the resident was mouth breathing and would not open his eyes even with tactile stimuli. The nurse placed a call to the resident's hospice agency and held all of his medications, food, and fluids. Record Review of Resident #7's Social Services Note dated [DATE] at 12:02 PM revealed the Social Worker was informed the resident had a decline. He was not eating or drinking. The charge nurse had spoken to the resident's guardian. The resident was on hospice. Record Review of Resident #7's Nurse's Note [DATE] 0:04 AM indicated the resident took his last breath and a call was placed to hospice. Record Review of the facility's COVID-19 Outbreak Tracking dated [DATE], indicated Resident #7's roommate, Resident #8, tested positive for COVID-19 on [DATE], two days before Resident #7. An observation on [DATE] at 10:35 AM, of the rooms on the Memory Care Unit, confirmed Resident #2 and #3, COVID-19 negative residents, remained assigned to rooms with COVID-19 positive residents (Residents #4 and #1). Resident #2 remained at the nurse's station in her wheelchair. Resident #2's roommate, Resident #4, was in bed in their shared room with no separation between the beds. Resident #3 was in her room, shared with Resident #1, and there was no barrier between their beds and the privacy curtain was not drawn. In an interview on [DATE] at 11:49 AM, the DON said the facility's policy was to not cohort COVID-19 positive residents with COVID-19 negative residents. She said she did not realize Residents #2 and #3 were being cohorted with COVID-19 positive roommates until today ([DATE]) when the Investigator began questioning the staff. She said the risk of COVID-19 transmission was high to the negative residents because they could contract COVID-19 from being cohorted with positive residents. She said so many residents began testing positive on the unit, it just did not compute that she had positive residents with negative residents. She said the negative residents should have been moved from the positive residents to prevent the spread of infection on the unit. She said Residents #2 and #3 were COVID-19 tested , once she realized they were cohorted with positive residents, and they both tested negative. She said room changes would be made today ([DATE]) to ensure Residents #2 and #3 were not in rooms with COVID-19 positive residents. Record Review of the facility's COVID-19 Infection Control and Mitigation Policy dated [DATE] indicated, under no circumstance should a COVID-positive resident be in the same room as a COVID-negative resident. If room isolation is not possible, such as for a dementia unit with wandering residents, try to set up smaller areas for wandering that reduces number of residents interacting and hence potential exposure and spread. In an interview on [DATE] at 11:07 AM, the Administrator said she contacted the RNC when the outbreak on the Memory Care Unit began. She said it was her understanding from the RNC to leave the residents cohorted on the unit. In an observation on [DATE] at 11:39, on the Memory Care Unit, revealed Resident #1 was in her wheelchair in the lobby by the nurse's station; she was not wearing her mask. Resident #2 remained in the lobby area in her wheelchair with her mask in place. Residents were wandering and intermingling. Resident #3 was in her room in bed. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 11:45 AM, LVN A said the COVID-19 positive, and COVID-19 negative residents had been cohorted since the outbreak started ([DATE]). She said there was a high risk of COVID-19 negative residents contracting COVID-19 from their roommates. In an interview on [DATE] at 1:56 PM, the Administrator said she called the corporate RNC on [DATE] to discuss the outbreak on the unit. She said she asked the RNC what to do about the positive and negative residents. She said the RNC told her the Memory Care Unit was different from the general population and the residents could stay where they were on the unit. She said the RNC said to try to do the best they could to keep the residents separated. She said the RNC did not say to move any of the positive or negative residents to different rooms. She said the RNC was at the facility on [DATE] and knew the residents on the unit were cohorted. In an interview on [DATE] at 2:05 PM, with the DON and Administrator, the DON said the facility would normally move a resident to a private room that tested positive for COVID-19, but because the RNC was a former State Surveyor, they felt she knew what to do, in regards, to the Memory Care Unit. She said, at the time of the outbreak on [DATE], the unit did not have enough available rooms to separate the residents, but the facility should have taken the negative residents out of the unit and provided, if needed, one on one supervision to keep them safe from elopement. The Administrator said today, [DATE], they were told by the [NAME] President of Clinical Operations they should not have cohorted the positive and negative residents on the unit and should have separated them. The Administrator said no curtain or other type of barrier was used in the rooms to separate negative residents from the positive residents. The Administrator was informed of the Immediate Jeopardy on [DATE] at 2:12 PM and was provided with the Immediate Jeopardy template. A Plan of Removal was also requested at that time. In a telephone interview on [DATE] at 2:13 PM, the RNC said the Administrator made her aware of the COVID-19 outbreak on the Memory Care Unit, but the Administrator misunderstood her instructions. She said the facility policy was to not cohort positive and negative residents. She said if she had known residents were cohorted, she and the team would have discussed what was best for the unit, to set up a separate space on the unit or move the negative residents off the unit. She said the risk of cohorting residents was that the negative residents could contract COVID-19 from being exposed to their roommates. She said she was at the facility on [DATE], but she did not go back to the Memory Care Unit and did not know or receive any information about residents with different COVID-19 statuses being cohorted together. In a confidential telephone interview on [DATE], a concerned party, said she was informed of the COVID-19 outbreak on the unit on [DATE], by LVN B. She said she asked LVN B how the facility was separating the positive and negative residents on the unit. She said LVN B told her they were just doing the best they could, and she if she had further questions to address them with the DON. She said she was very afraid all the residents would contract COVID-19 on the unit. She said she was very upset the facility was not following the infection control guidelines to prevent the spread of the infection. In an observation on [DATE] at 10:44 AM, on the Memory Care Unit, revealed Residents #2 and #3 (COVID-19 negative) were placed in private rooms. Resident #2 was in the lobby, sitting in her wheelchair. She did not have her mask on, five other COVID-19 positive residents were also in the lobby without masks on. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview on [DATE] at 10:47 AM, CNA C, who was working on the Memory Care Unit, said COVID-19 positive residents had been cohorted with negative residents on the unit since the outbreak. She said she did not feel that was good infection control practices, but she did not ask anyone about it. She said she believed positive and negative residents should be separated to prevent the spread of infection. She said she most of the residents wander all around, in and out of each other's rooms. She said the residents on the unit would not wear their mask. She said on Saturday ([DATE]), Resident #6 told her she was concerned she might contract COVID-19 from her roommate, who was coughing and had symptoms. She said Resident #6 was negative and her roommate, Resident #5 was positive. She said she also overheard Resident #6 discussing her concerns with her family on the phone. She said Residents #5 and #6 were still roommates. Record Review of Resident #6's Admission Record dated [DATE] indicated the [AGE] year-old female resident was admitted to the facility on [DATE] with a diagnosis of behavioral disturbances. She was COVID-19 positive on [DATE]. She was roommates with Resident #5. Record Review of the facility's COVID-19 Outbreak Tracking dated [DATE], indicated Resident #6's roommate, Resident #5, tested positive for COVID-19 on [DATE], three days before Resident #6. Record Review of Resident #6's census record from [DATE] - [DATE] indicated she remained roommates with Resident #5. Record Review of Resident #6's quarterly MDS dated [DATE] indicated the resident was moderately cognitively impaired with a BIMS score of 9 (a score of ,d+[DATE] indicated moderate cognitive impairment). In an observation and interview on [DATE] at 10:49 AM revealed Resident #6 was in her room, her roommate, Resident #5, was also in the room. Resident #6 said she contracted COVID-19 from her roommate. She said she was concerned when her roommate became positive that she would contract COVID-19 because she remained in the room with her. She said positive residents also wandered in her room and roamed all over the unit. She said residents would not wear a mask. She said she was not having any signs or symptoms of COVID-19 at this time. In a telephone interview on [DATE] at 12:18 PM, the Medical Director said he was not aware of the cohorting of COVID-19 positive and negative residents on the Memory Care. He said residents should not have been cohorted due to the high risk of the spread of the infection. He said he had spoken to the Administrator and believed, as of [DATE], the facility had taken the appropriate actions to fix the problem and ensure this did not happen again. In a telephone interview on [DATE] at 1:59 PM, Resident #2's responsible party said the facility informed her of the COVID-19 outbreak. She said yesterday ([DATE]) the facility called her to let her know they were moving Resident #2 to another room because her roommate had tested positive for COVID-19 and the facility did not want Resident #2 to contract COVID-19. She said she was always concerned the resident might contract COVID-19, since the pandemic began, and with the resident's health conditions she was not sure how the resident would do if she contracted it. She said she resided out of state and was not able to come to the facility to visit the resident. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview on [DATE] at 2:19 PM, the Medical Director's Nurse Practitioner said she was not aware residents who were COVID-19 negative were being cohorted with residents who were COVID-19 positive on the Memory Care Unit. She said she did know most of the residents on the unit were COVID-19 positive. She said she was not surprised the infection spread on the unit because everyone on the unit had been exposed and COVID-19 was so contagious. She said residents on the unit wandered and would not wear masks. She said Resident #7 was on hospice related to his cancer diagnosis prior to contracting COVID-19. She said he had comorbidities that impaired his immune response to fight off infection. She said COVID-19 may have played a part in his passing but she did not know how much he did not present with the classic respiratory symptoms. She said she would review his closed clinical record and provide more information. In an interview on [DATE] at 2:51 PM, LVN D said he did not think that COVID-19 positive and negative residents should be cohorted, but he never asked anyone about it. He said he could see the concern of moving wandering residents off the Memory Care Unit and the risk for elopement. He said on the Memory Care Unit it was impossible to isolate the residents because they wandered and would not wear masks. He said residents just being in the unit caused the spread of the infection because residents go in each other's rooms, touch things, and get together in groups. In a telephone interview on [DATE] at 3:09 PM, LVN B, who worked the Memory Care Unit, said she expressed serious concern to the DON when the first resident, Resident #9 tested positive ([DATE]) on the Memory Care Unit. She said Resident #9 should have been moved off the unit to try to stop the spread of the infection. She said Resident #9 could have been moved off the unit to the COVID-19 hall because the resident was not at risk for elopement because she was ill and not getting out of bed. She said she wanted to separate the positive and negative residents to try to contain the infection. She said she told the DON her concerns, but the DON said all the residents on the unit were exposed and going to get it anyway. She said the DON knew positive and negative residents were in the same room together on the unit. She said she called the Nurse Practitioner to discuss her concerns, she did not remember the date. She said the Nurse Practitioner knew the positive negative residents were cohorted on the unit. She said the Nurse Practitioner told her all the residents were going to get COVID-19 anyway because it was so contagious. She said the overall philosophy was that all the residents had been exposed and were going to get COVID-19 on the unit. She said no interventions were put in place to try to keep COVID-19 from spreading on the unit. She said the nurses and CNAs cleaned as much as they could. She said because it's a Memory Care unit, no matter how hard they tried they could not keep wandering residents from going in each other's rooms, or wear masks. She said positive residents were going up to negative residents and talking to them without masks on. She said one by one residents on the unit tested positive for COVID-19. She said she could not say whether or not Resident #7 expired from COVID-19, but it probably contributed to his decline. In a telephone interview on [DATE] at 3:29 PM, the Nurse Practitioner said she had reviewed Resident #7's closed clinical record and believed from the documentation in the record he expired from a pulmonary embolism (a blood clot to his lungs). She said COVID-19 could cause blood clots but usually after an extended illness and Resident #7's was a more rapid decline. She said she did not believe COVID-19 had a lot to do with his death but an autopsy would be the only way to know for sure. In an interview on [DATE] at 4:09 PM the DON said all the licensed nurses had been in-serviced regarding the policy on cohorting on [DATE]. She said all the licensed nurses would be in-serviced before working their shifts. She said she would work this weekend and in-service the weekend staff. She said the in-service would be on-going for new hires and any agency staff. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The facility's POR (Plan of Removal) was accepted on [DATE] at 11:26 AM and reflected the following: Problem: Two residents on the secure unit were cohorted in their rooms with negative roommates. o Action Positive and negative residents were separated by licensed nurse under the direction of the Director of Nursing and isolated in accordance with CDC (Centers for Disease Control) protocols on [DATE]. o Families of negative residents were notified by DON on [DATE]. o Medical Director was notified by Administrator on [DATE]. o Both negative residents were tested by licensed nurse on [DATE] and remained negative. o Both negative residents will be monitored q shift x 72 hours by licensed nurse for signs and symptoms of COVID and this assessment will be documented in the electronic medical record. Problem: The facility was under the impression that due to the outbreak on the secured unit, COVID positive and negative residents could remain together. o Action on [DATE], Lead CCS (Corporate Clinical Specialist) in-serviced Director of Nursing, Administrator, Regional Director of Operations and Corporate Clinical Specialist on COVID policies and procedures to include proper cohorting and management of positive residents and negative roommates. o On [DATE], Director of Nursing, Regional Corporate Clinical Specialist (CCS) and LEAD CCS completed in-servicing with licensed nurses on COVID protocols to include proper cohorting and management of positive and negative residents. No licensed nurses will be allowed to work without receiving this in-service prior to reporting for duty. This in-service material will be incorporated into new hire orientation effective [DATE]. Currently the facility does not use agency staff, but in the event agency staff is needed, they will not be utilized until they have completed the required in-service. Monitoring o In order to monitor residents for potential risk, proper cohorting, and isolation/quarantine, the DON will review the status of all new admissions, PUI, and COVID-positive residents on a daily basis with lead CCS beginning [DATE]rd, 2022, for 30 days. Facility administrator will ensure that DON reviews residents with lead corporate nurse daily for 30 days. o The facility QA (Quality Assurance) Committee will meet weekly for the next eight weeks to review compliance. If no further concerns are noted, will continue to monitor as per routine facility QA Committee. Facility administrator will be responsible to ensure that meeting occurs weekly. The following interviews, and record reviews were conducted to verify the implementation of the facility's Plan of Removal and revealed the following: (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's in-service and training records, COVID Protocols dated [DATE], indicated all the licensed nurses would be in-serviced on the proper cohorting of COVID-19 positive and negative residents. Positive and negative COVID-19 residents could not remain in the same room. The COVID-19 negative resident must be moved to a single room. Staff were to encourage residents to wear masks. Staff must make every effort to keep COVID-19 positive and negative residents separated, at all times. The DON and Administrator must be notified immediately of any new COVID-19 cases. Interviews were conducted with staff across multiple shifts, the shifts were 6:00 AM - 2:00 PM, 2:00 PM - 10:00 PM and 10:00 PM - 6:00 AM, on [DATE] from 10:55 AM through 4:30 PM, including, the Administrator, DON, MDS Coordinator, Medical Director and six LVNs, A, B, D, E, F, and G. They were able to verbalize the appropriate understanding of cohorting residents based upon COVID-19 status, and the plan of removal. Review of rapid testing results from [DATE] revealed Resident #2 and #3 tested negative for COVID-19. An Immediate Jeopardy was identified on [DATE] at 2:12 PM. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a severity level of actual harm that was not Immediate Jeopardy and a scope of pattern because the facility was still monitoring the effectiveness of their Plan of Removal.