STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455713	A. BUILDING _____ B. WING _____	05/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNRISE NURSING & REHAB CENTER	50 BRIGGS ST SAN ANTONIO, TX 78224

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to 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 infections and follow accepted national standards, to include hand washing, for 3 of 3 Residents (Residents #1, #2, #3) reviewed for isolation precautions and hand hygiene, in that: A. CNA B donned PPE when entering Residents #2 and #3's room who were on droplet isolation precautions. B. CNA B and LVN A failed to donned PPE (Personal Protective Equipment) in the correct sequence before entering residents' rooms (rooms [ROOM NUMBERS]) who were on droplet isolation precautions. CNA B also failed to wash or sanitize her hands after touching contaminated surfaces with her gloves and before putting on a new pair of gloves. This deficient practice could place residents, staff and visitors at risk of transmission of communicable diseases, illness, infections and COVID-19. The findings included: A. Review of Resident #2's Face Sheet, dated 5/13/20, revealed the resident admitted to the facility on ,[DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Review of Resident #3's Face Sheet, dated 5/13/20, revealed the resident admitted to the facility on [DATE] and readmitted on [DATE] with the following [DIAGNOSES REDACTED]. Record review of the facility's resident roster, undated, revealed Residents #2 and #3 resided in room [ROOM NUMBER]. During an interview on 5/12/20 at 2:32 p.m., the DON reported the facility had designated the 200 Hall as the facility's isolation/quarantine wing. The DON reported the 200 Hall currently had residents who admitted or readmitted back into the facility in the past 14 days, required [MEDICAL TREATMENT] treatments, had outside appointment and/or any resident who exhibited signs/symptoms of COVID-19. The DON further reported the resident on the 14-day observation were on droplet precautions. The DON also reported that no residents in the facility were exhibiting signs/symptoms of COVID-19 nor had a true organism-based infection requiring transmission-based precautions. Initial tour observations of the 200 Hall on 5/12/20 at 3:28 p.m., revealed three resident rooms (203,208, and 209) had isolation carts and a droplet precaution sign on the door which stated to keep door closed, perform hand hygiene before entering the room, and wear gloves, gown, face mask, face shield while in the room. Further observation in the isolation cart revealed there were individually bagged set of PPE (gloves, gown, surgical face mask, and booties) in the draws. Observation on 5/12/20 at 4:41 to 4:42 p.m., revealed LVN A and CNA B were on the hall in a surgical face mask and face shield. Observation also revealed the dinner meal cart arrived at the door of the 200 hall. CNA B entered room [ROOM NUMBER], a droplet isolation room, with a resident's tray without donning the PPE as listed on the sign on the door (gown, gloves, mask and face shield). CNA A placed the tray on Resident #2's bedside table and helped him set it up to eat. During an interview on 5/12/20 at 4:43 p.m., LVN A confirmed CNA B was in an isolation room and did not put on PPE in the isolation cart before entering the room as she should. During an interview on 5/12/20 at 4:55 p.m., CNA B confirmed she did not don the PPE in the isolation cart before entering room [ROOM NUMBER] who was on isolation. CNA B reported she forgot to put on the PPE because she was in a hurry to get the resident his food. B. During an interview with LVN A on 5/12/20 at 4:40 p.m., when asked what order the LVN would put on the PPE before going into the droplet isolation rooms, LVN A reported he would first put on a new surgical mask, gown, booties and then lastly his gloves. LVN A confirmed resident rooms 203, 208 and 209 were on the droplet isolation precautions. Observation on 5/12/20 at 4:45 p.m., revealed CNA B with Resident #4's dinner tray, who was in room [ROOM NUMBER], a droplet isolation room. CNA B gave LVN A Resident #4's tray to hold while she put on the PPE. CNA opened the isolation cart draws and pulled out a baggie of PPE. CNA B put on the gloves first, then put on her gown and tried to tie the strings behind her neck and touched her hair with her gloves on. CNA B tied the gown and proceed to put on the booties with her gloved hands. CNA B touched her shoes with her gloved hands. LVN A confirmed CNA B touched her shoes with her gloved hands while trying to put on her booties. LVN A also confirmed with the surveyor that CNA B must change her gloves. CNA B took off the gloves and grab a new pair of gloves without washing or sanitizing her hands, and lifted the trash can lid with her hands. LVN A confirmed CNA B touched the trash can and she did not wash or sanitizer her hands before putting on the new gloves. LVN A CNA B must sanitize her hands and put on a new pair of gloves. CNA B stated the hand sanitizer was all the way at the end of the hall. LVN A stated that she could wash her hands instead. CNA B washed her hands and then put on the mask and new gloves and entered the room. Observation on 5/12/20 at 4:51 p.m., revealed LVN A outside of room [ROOM NUMBER], a droplet isolation room. LVN A gave CNA B Resident #5's tray to hold while he donned the PPE before entering the room. LVN A went into his office that facility made for him and sanitized his hands with hand sanitizer. LVN A took of the mask he had on, put on a new one from the bagged PPE, then put on the gown, booties, sanitized his hands and then put on the gloves. During the daily debriefing with the Administrator and DON on 05/12/20 at 5:55 p.m., they were informed of the above observations and interviews. The DON confirmed LVN A and CNA B did not follow proper procedure. The DON stated CNA should have gowned before entering the isolation room. The DON confirmed there were 3 residents on the droplet precautions in the 200 hall and that staff are to wear the PPE before going in and put it on in the correct order. During an interview on 5/13/20 at 12:54 p.m., the DON reported the facility's physicians were all in agreement with the facility's policy to place the resident's admitting or re-admitting from the hospital or coming back to the facility from an appointment are to be placed on a 14-day droplet precaution isolation. The DON reported no written policy on observational droplet precautions, but that this was the policy direction she received from corporate. Record review of the facility's Infection Prevention Handout, undated, revealed to limit the surfaces that you touch (.) if you touch anything be sure to preform hand hygiene immediately afterwards. (.) If the resident is on special precautions requiring special protective equipment a posting(s) will be placed at the entrance of the resident's room. Ask the nurse for assistance prior to entering the room. Record review of the CDC's educational guide on Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19, dated 3/30/20, revealed 1. Identify and gather the proper PPE to don. Ensure choice of gown size is correct (based on training). 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. Tie all of the ties on the gown. Assistance may be needed by another HCP. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). (.) 5. Put on face shield or goggles. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common. 6. Perform hand hygiene before putting on gloves. Gloves should cover the cuff (wrist) of gown. 7. HCP may now enter patient room. (https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf) Review of the facility's COVID-19 Plan, dated 3/12/20, revealed in the section on Keys to an Effective Control Program includes adhering to a special precautions (isolation). Review of the Center for Disease Control (CDC) Hand Hygiene Guidance dated 01/30/2020 reflected .Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications .after contact with contaminated surfaces (and) immediately after glove removal. Record review of the facility's policy on Hand Washing, dated 10/2017, revealed employees must wash their hands for 20 seconds using antimicrobial or antimicrobial soap and water under the following conditions: (.) before and after entering isolation precaution settings (.) after handling soiled equipment or utensils (and)( ) after removing gloves or apron.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1)
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a functional, safe and sanitary environment for residents and family members/public in that: 1. On the 200 Hall, there was a stripped resident bed which had a dark brown lumpy smooshed substance on the flattened part of the bedframe. 2. In the North Dining room were pieces of a sandwich, other food crumbs and a white unidentifiable pill. 3. In the 300 hallway had several black wheelchair skid marks and dried coffee stains on the floor. 4. In room [ROOM NUMBER], the part of the privacy curtain was on the floor and not hung completely on the curtain track of the ceiling. These failures could affect all residents and their visitors and placed them at risk of illness and decreased quality of life. Findings include: 1. Observations on 5/12/20 at 3:33 p.m., revealed a beige bedframe in the hallway of the 200 hall between the doorway ways of resident room's 205 and 207. Further observation of the bedframe revealed a dark brown lumpy and smooshed substance about 2 inches in diameter on the long end of the bedframe facing outwards towards the hallway where staff and residents would pass by. During an interview on 5/12/20 at 3:33 p.m., LVN C confirmed the bedframe revealed a dark brown lumpy and smooshed substance on the long end of the bedframe facing outwards towards the hallway where staff and residents would pass by. During an interview on 5/12/20 at 3:36 p.m., LVN A confirmed the bedframe revealed a dark brown lumpy and smooshed substance on the long end of the bedframe facing outwards towards the hallway where staff and residents would pass by. LVN A reported they had moved the bed out of 210 so they could make a temporary nursing station for the nursing staff working on the 200 hall so they don't have to leave the unit. LVN A also reported he had not noticed the substance on the bedframe, but he would let maintenance know. 2. Observations on 5/12/20 at 3:56 p.m., revealed Resident #1 was seated at the table with no food tray or plate in front of him, but there was a blue face mask on the table. Further observation revealed were pieces of a sandwich, other food crumbs and a white unidentifiable pill on the floor. During an interview with LVN C on 5/12/20 at 2:54 p.m., LVN C reported residents are eating their meals in their rooms, and if there were any residents that needed assistance the CNAs would go into their rooms to help. During an interview on 5/12/20 at 3:57 p.m., the Housekeeping and Laundry Supervisor confirmed the dining room had pieces of a sandwich and other food crumbs on the floor. During an interview on 5/12/20 at 3:58 p.m., LVN D reported Resident #1 was in the dining room because he needed to be supervised and that he had taken off his mask because he did not want to wear it. The DON also reported Resident#5 was confused and on hospice services. LVN D confirmed there was a white unidentifiable pill on the floor and said that it looked sucked and spit out. LVN D reported that she thought it was one of the resident's medications, but when she looked though his pill blister packs in the medication cart she could not find one that matched the pill on the floor. 3. Observations on 5/12/20 at 3:33 p.m., revealed in the 300 hallway there were several black wheelchair skid marks and dried coffee stains on the floor. During an interview on 5/12/20 at 3:53 p.m., the Housekeeping and Laundry Supervisor confirmed on the 300 hallway there were several black wheelchair skid marks and dried coffee stains on the floor. 4. Observations on 5/12/20 at 3:47 p.m., revealed in room [ROOM NUMBER] no residents in the room, but the privacy curtain for the A bed was partly on the floor and not hanging from the curtain track. During an interview on 5/12/20 at 3:50 p.m., LVN D confirmed the privacy curtain in resident room [ROOM NUMBER] for the A bed was partly on the floor and not hanging from the curtain track. LVN D revealed she was not aware the curtain was not on the track completely. During an interview on 5/12/20 at 3:59 p.m., the DON confirmed the privacy curtain in resident room [ROOM NUMBER] for the A bed was partly on the floor and not hanging from the curtain track. During an interview on 5/13/20 at 2:13 pm interview with Housekeeping and Laundry Supervisor revealed the housekeeping staff perform daily cleaning of the facility and if need then they will return again to clean an area upon request. The Housekeeping and Laundry Supervisor revealed they did not have a specific policy on housekeeping.