STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676301	A. BUILDING _____ B. WING _____	**03/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN WINDS LIVING & REHABILITATION	**3301 FM 3009 SCHERTZ, TX 78154**

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that a resident who entered the facility without an indwelling catheter was not catheterized unless the clinical condition demonstrated that catheterization was necessary for 1 of 1 residents (Resident #1) reviewed, in that: Resident #1 was catheterized unnecessarily due to urinary E. Coli (an infection that can cause a urinary tract infection). This deficient practice could place residents with urinary tract infections at risk of loss of continence and poor quality of life. The findings were: Record review Resident #1's face sheet, dated 3/7/20, revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's nurse's note dated 3/6/20 revealed Resident #1 arrived to the facility at 3:15 p.m. and did not want a indwelling catheter because she was sore near her urethra (duct where urine is conveyed) and was worried about getting another UTI. Resident #1 was under contact isolation precautions for urinary E. Coli. Review of Resident #1's nurse's note dated 3/7/20 revealed an indwelling catheter was inserted and with the insertion, infection in the urine was contained and precautions discontinued. Review of Resident #1's physician's orders [REDACTED].#1's door was closed with personal protective equipment outside the bedroom with no identifying sign indicating Resident #1 was on isolation due to infection. During an interview with Resident #1 on 3/7/20 at 1:16 p.m. revealed she did not want the catheter but was told she had to have it for isolation and she had fecal matter in her urine. Resident # 1 stated she was continent of bowel and bladder. During an interview with the DON on 3/7/20 at 12:49 p.m. revealed they normally did not put a resident in isolation for E. Coli in the urine. The DON further revealed she contacted the NP who stated to put in a catheter and take Resident #1 off isolation. The DON contacted the NP back after Resident #1 declined the catheter and the NP stated she would come to the facility that evening (3/6/20). The NP came in and placed an order for [REDACTED].#1 was continent. During an interview with Resident #1 on 3/7/20 at 1:00 p.m. with the DON present revealed someone came in Friday evening (3/6/20) with long black hair and stated I had to have the catheter. I did not want it, but I said ok. During an interview with the DON on 3/7/20 at 1:15 p.m. confirmed that Resident #1 described the NP as she did not have staff with long black hair that worked at night. During an interview with the NP on 3/7/20 at 1:58 p.m. revealed she came to the facility on the evening of 3/6/20 and spoke to Resident #1. The NP confirmed the catheter was placed to keep Resident #1 out of isolation. The NP further revealed she told Resident #1 that the catheter could be removed after the antibiotics were completed. During an interview with the DON on 3/7/20 at 2:10 p.m. revealed she spoke with the NP who told Resident #1 it would be better if she had a catheter, so the infection did not spread. The DON confirmed Resident #1 was continent and the facility could just have continued the isolation. The DON further confirmed she did not think Resident #1 needed the catheter. During an interview on 3/7/20 at 2:21 p.m. the DON revealed they did not have a policy related to unnecessary catherization.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 1 of 1 Resident (Resident #1) on isolation to prevent the spread of infection in that: 1. There was no identifying sign at the entrance area of Resident #1's room to indicate Resident was on isolation. 2. a. Disposable gowns were wadded up and sitting on top of the isolation cart outside of Resident #1's room. b. Gowns that were used for isolation were previously used during a fair for staff to learn how to use PPE (personal protective equipment). This deficient practice could place residents, staff and visitors at risk for cross contamination to prevent the development and transmission of communicable diseases and infections. The findings were: 1. Record review Resident #1's face sheet, dated 3/7/20, revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's physician's orders for March 2020 revealed an order for [REDACTED].#1's nurse's note dated 3/6/20 revealed Resident #1 arrived to the facility at 3:15 p.m. and was under isolation precautions for urinary E. Coli. Observation on 3/7/20 at 8:45 a.m. revealed Resident #1's door was closed with personal protective equipment outside the bedroom with no identifying sign indicating Resident #1 was on isolation due to infection. During an interview on 3/7/20 at 8:50 a.m. with LVN A revealed Resident #1 was in isolation for E. Coli to the urine. LVN A confirmed there was no signage on the door. During an interview on 3/7/20 at 9:22 a.m. the Administrator confirmed there should have been a sign on Resident #1's door since she was in isolation. 2. Observation on 3/7/20 at 8:45 a.m. revealed disposable gowns were wadded up and sitting on top of the isolation cart outside of Resident #1's room. During an interview on 3/7/20 at 8:50 a.m., LVN A revealed the gowns were usually in the drawer in a package. During an interview on 3/7/20 at 9:00 a.m., CNA B revealed she did not know if the disposable gowns were clean. CNA B stated Look at the gowns. One looks like the string was tied and cut. During an interview on 3/7/20 at 9:05 a.m., RN D revealed she got the gowns out of the box and they just fell out when she opened them. During an interview on 3/7/20 at 9:22 a.m., the Administrator revealed they had been searching for disposable gowns like everyone else. The Administrator stated he did not know if the gowns were clean or not. During an interview on 3/7/20 at 10:40 a.m., the ADON revealed the disposable gowns are on back order and she found some gowns that had been used at a health skills fair. The ADON stated that people at the fair did put on the gowns to practice putting on PPE. Review of the facility policy titled Equipment and Supplies Used During Isolation dated April 2012 revealed 2. All such equipment and supplies shall be stored and maintained in according with appropriate isolation precautions, consistent with the manufacturer's recommendations. Review of the facility policy titled Personal Protective Equipment - Using Gowns dated October 2010 revealed 1. Use gowns only once and then discard into an appropriate receptacle inside the exam or treatment room.

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