STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675678	A. BUILDING _____ B. WING _____	07/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARECHOICE OF BOERNE	200 E RYAN ST BOERNE, TX 78006

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 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 for 2 of 5 residents (Residents #1 and #2) reviewed for infection control, in that: 1. State surveyor was not screened for COVID-19 upon entrance to facility. 2. A plastic bag that contained a dirty brief and 2 empty wipe packages was in the hallway on the floor between two resident rooms. 3. Resident #1 did not have signage on his door that indicated he was in quarantine. 4. Resident #2 did not have signage on his door that indicated he was in quarantine and did not have biohazard boxes in his room. These deficient practices could place residents, staff and visitors at risk of transmission of communicable diseases, illness, infections and COVID-19. The findings included: 1. Observation on 7/1/2020 at 7:15 a.m. revealed a CNA let the state surveyor into the facility and did not screen the surveyor for signs/symptoms of COVID-19. In an interview on 7/1/2020 at 8:45 a.m. the Administrator revealed when an employee or visitor came into the building and it was after hours whomever answered the door was responsible for screening the person or the charge nurse should do it. Each person should take their own temperature and then someone needed to verify it. The Administrator confirmed the staff member who answered the door this morning should have verified the surveyor's temperature and screened them for COVID-19. 2. Observation on 7/1/2020 at 7:42 a.m. revealed a plastic bag containing a dirty brief and 2 empty wipe packages was in the hallway floor between rooms [ROOM NUMBERS]. In an interview on 7/1/2020 at 7:43 a.m. RN C confirmed the brief was dirty and there were empty wipe packages inside the plastic bag. RN C further confirmed the plastic bag should not be on the floor. In an interview on 7/1/2020 at 9:25 a.m. the DON revealed when a staff member comes out of a resident's room with dirty linens or trash there are barrels on the hall where it should be placed. The DON confirmed the plastic bag with the dirty brief and empty wipe packages should not have been placed on the floor. 3. Review of Resident #1's face sheet, dated 7/1/2020, revealed he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation on 6/30/2020 at 3:20 p.m. revealed a quarantine cart outside of Resident #1's room, but no signage on his door. Observation on 7/1/2020 at 7:19 a.m. revealed a quarantine cart outside of Resident #1's room, but no signage on his door. In an interview on 7/1/2020 at 7:19 a.m. RN C revealed Resident #1 was in quarantine and confirmed there was no signage on his door. In an interview on 7/1/2020 at 8:27 a.m. the ADON confirmed there was no signage on Resident #1's door and there should be as he was in quarantine. In an interview on 7/1/2020 at 9:25 a.m. the DON revealed residents in isolation or quarantine should have signage on their door. The DON confirmed Resident #1 should have had signage on his door as he was in quarantine. 4. Review of Resident #2's face sheet, dated 7/1/2020, revealed he was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. Observation on 6/30/2020 at 3:20 p.m. revealed a quarantine cart outside of Resident #2's room, but no signage on his door. Observation on 7/1/2020 at 7:20 a.m. revealed a quarantine cart outside of Resident #2's room, but no signage on his door. Observation on 7/1/2020 at 8:09 a.m. revealed CNA B entered Resident #2's room with his breakfast tray wearing a gown, mask and gloves, leave his room and walk down the hallway, and enter Resident #2's room again with a cup of coffee. CNA B then left Resident #1's room without changing her gown or gloves. Observation on 7/1/2020 at 8:14 a.m. revealed there were no biohazard boxes in Resident #2's room. In an interview on 7/1/2020 at 7:20 a.m. with RN C revealed Resident #2 was in quarantine and confirmed there was no signage on his door. In an interview on 7/1/2020 at 8:23 a.m. CNA B revealed she was unaware Resident #2 was in quarantine because there was no signage or biohazard boxes in his room. In an interview on 7/1/2020 at 8:27 a.m. the ADON confirmed there was no signage on Resident #2's door and no biohazard boxes in his room and there should be as he was in quarantine. In an interview on 7/1/2020 at 9:25 a.m. the DON revealed any resident in isolation or quarantine should have signage on their door and biohazard boxes in their room. She confirmed Resident #2 should have had signage on his door and biohazard boxes in his room as he was in quarantine. Review of the facility policy titled, Personal Protective Equipment - Using Gowns dated September 2010 revealed, Removing the Gown - 2. Remove gloves and discard them into a waste receptacle in the room. 6. If the gown is disposable, discard it into the waste receptacle inside the room. Review of the facility policy titled, Quarantine dated November 2011 revealed, The facility will protect the health and well-being of our residents and staff during infectious disease outbreaks. Quarantine is generally enacted by governmental authorities. 1. Should quarantine be declared, the Administrator, with the input of the Medical Director and Director of Nursing Services, will work with governmental authorities to implement quarantine practices appropriate for the specific threat and as directed by authorities. Review of the facility policy titled, Protocol for Acceptance of Admission and Readmission, dated March 19, 2020 revealed, 4. Prior to readmission, the team will determine if the resident will need to be in isolation. If yes, the appropriate isolation room will be set up completely. The room will be checked by the DON or designee before the resident is placed in the room. 5. Every resident who is readmitted will be under surveillance including vital signs every shift and close monitoring to observe for respiratory symptoms. The resident may not have been diagnosed with [REDACTED]. Review of the CDC guidelines dated June 25, 2020 Preparing for COVID-19 in Nursing Homes revealed, Screen visitors for fever (Temp equal of great than 100.0 degrees F), symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility.

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