STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675134	A. BUILDING _____ B. WING _____	**04/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHISPERING OAKS REHAB & NURSING	**105 HOSPITAL DR CUERO, TX 77954**

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.** Based on observation, interview and record review, the facility failed to develop and implement an infection 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 6 of 9 residents reviewed for medication pass (Resident #1, #2, #3, #4, #5, #6), in that: 1. LVN A did not sanitize reusable medical equipment between residents (Residents #1, #2, #3) during medication pass. 2. LVN A did not perform hand hygiene after touching contaminated surfaces and objects before returning to preparing and providing medications. These deficient practices could place residents who receive medications at risk for cross-contamination and/or spread of infection. The findings were: 1. During an interview on 4/15/20 at 4:03 pm, LVN A stated she has been passing medications in the evening shift for about one year. Observation on 4/15/19 at 4:10 pm revealed LVN A placed a wrist blood pressure monitor on Resident # 1, without sanitizing it. Observation on 4/15/19 at 4:11 pm revealed LVN A walked out of Resident # 1's room and placed the wrist blood pressure monitor on top of the medication cart to the left, however, she did not sanitize the blood pressure monitor. Observation on 4/15/19 at 4:27 pm revealed LVN A placed the same wrist blood pressure monitor on Resident # 2 without sanitizing it first. Observation on 4/15/19 at 4:29 pm revealed LVN A then placed the same wrist blood pressure monitor on top of the med cart and did not sanitize it. Observation on 4/15/19 at 4:36 pm revealed LVN A placed the same wrist blood pressure monitor on Resident # 3, without first sanitizing it. During an interview 4/15/19 at 5:01 pm, LVN A stated she usually wiped the blood pressure monitors between residents but forgot to today. During an interview on 4/16/20 at 12:25 pm, the DON stated all staff were supposed to sanitize blood pressure monitors between residents. 2. Observation on 4/15/19 at 4:37 pm revealed LVN A unlocked the med cart to prepare the medications for Resident # 3, including two capsules and eye drops, without performing hand hygiene. Observation on 4/15/19 at 4:39 pm revealed LVN A brought the two capsules in a medication cup and a cup of water into Resident # 3's room and, in the process, touched the rim of the water cup where the resident places her lips. Observation on 4/15/19 at 4:40 pm., LVN A provided the medication to Resident # 3 and Resident # 3 took the pills into her mouth and drank from the water cup. Observation on 4/15/19 at 4:41 pm revealed LVN A performed hand hygiene, documented in the medication binder using a pen, and then proceeded to prepare Resident # 4's medication, including three capsules. Observation on 4/15/19 at 4:44 pm revealed LVN A picked up Resident # 4's medication cup with her forefinger and thumb while touching the rim. LVN A then provided the medication cup to Resident # 4 and Resident # 4 brought the medication cup up to her lips and swallowed the medication. Observation on 4/15/19 at 4:53 pm revealed LVN A then flipped through the binder on the med cart looking for Resident # 5's paperwork and did not perform hand hygiene after she administered the medication to Resident #4 Observation on 4/15/19 at 4:55 pm revealed LVN A touched the med cart keys and unlocked the cart and began to prepare Resident # 5's medication. She did not perform hand hygiene and then touched the rim of the water cup where the resident placed her lips. Observation on 4/15/19 at 4:56 pm revealed LVN A then administered Resident #5's medication. Resident # 5 placed the capsules in her mouth and drank from the water cup. Observation on 4/15/19 at 4:59 pm revealed LVN A documented in the medication binder using a pen and did not perform hand hygiene after administering Resident's #5 medication. LVN A prepared Resident # 6's medication, but touched the rim of the medication cup with her hands. LVA A then administered Resident's #6 medication. Further observation reveled Resident#6 touched the med cup to his mouth to take the capsule. During an interview on 4/15/19 at 5:01 pm, LVN A stated she performs hand hygiene after each person and after every third resident she washes her hands. LVN A stated she typically tried not to touch the rims of medication cups and water cups. During an interview on 4/16/20 at 12:25 pm, with DON acknowledged that staff who pass medications should avoid touching the rims of water and medication cups, if resident were going to be touching their mouths to the cups. Record review of a facility policy titled, Infection Control Guidelines, revised on 9/22/17, read staff shall use hand hygiene between patient contacts, after handling contaminated objects and standard precautions shall be observed for all residents. Record review of a facility policy titled, Infection Control Guidelines, revised on 9/22/17, read All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with current procedures governing the cleaning and sterilization of soiled and contaminated equipment. Record review of a facility policy titled, Medication Treatment Administration and Documentation Guidelines, revised on 2/2/14, did not address infection control guidelines related to medication pass.

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.