STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676023	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KELLER OAKS HEALTHCARE CENTER	8703 DAVIS BLVD KELLER, TX 76248

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews 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 for three (Residents #1, #2 and #3) of three residents and four (CNA A, CNA B, LVN C and CNA D) of four staff reviewed for infection control practices. 1. CNA A and CNA B failed to perform hand hygiene while providing incontinence care to Resident #1. 2. LVN C failed to wear proper personal protective equipment when going into presumptive COVID-19 positive resident rooms. 3. CNA D failed to wear proper personal protective equipment when going into presumptive COVID-19 positive resident rooms. These failures placed residents at risk for healthcare associated cross-contamination and infections. Findings Included: 1. Review of Resident #1's Admission Record, dated 09/28/20, revealed she was a [AGE] year-old female re-admitted to the facility on [DATE]. Resident #1 had [DIAGNOSES REDACTED]. Review of Resident #1's re-entry Minimum Data Set (MDS) assessment, dated 06/20/20, revealed she required extensive assist of one person for bed mobility and was frequently incontinent of bowel and bladder. Observation on 09/18/20 at 11:15 AM of incontinent care for Resident #1, being provided by CNA A, revealed Resident #1 had a large bowel movement. After washing her hands and donning gloves, CNA A cleaned the resident's front peri area, turned her to her right side and cleaned her bottom. Resident #1's draw sheet and fitted sheet were soiled with urine and stool and CNA A realized she had forgotten to get clean linens and verbalized she needed to go get the clean linens. CNA A removed her gloves, and without washing her hands, left Resident #1's room to retrieve clean linens. Approximately two minutes later CNAs A and B came back into the room, and without washing their hands, put gloves on. CNA A took the soiled, fitted sheet off from the left side of Resident #1's bed and along with the soiled draw sheet rolled them up and under the residents' right side as CNA B held Resident #1 on her right side with the soiled sheets rolled up under her. Without changing gloves or sanitizing her hands CNA A got the clean fitted sheet and placed it on the left half of the bed, got the clean draw sheet, and a clean brief and placed them under Resident #1's right side under the dirty sheet and draw sheet. Together the CNAs rolled Resident #1 to her left side. CNA B then pulled the soiled linen out from under Resident #1, and from the bed, and placed them in a plastic bag. Then without changing her gloves or performing hand hygiene, CNA B rolled the clean linens and brief from under Resident #1 and placed the clean fitted sheet on the right side of the bed, rolled the draw sheet and clean brief out and together the CNAs put Resident #1 on her back. CNA A brought the brief up through Resident #1's legs and together the CNAs fastened her brief, pulled her gown down, pulled her up in bed, covered her with a sheet and blanket, put her HOB up and foot of bed down, and placed her call light in her reach. After removing their gloves, the CNAs then picked up the dirty linens and trash and went into the bathroom and washed their hands. In an interview on 09/18/20 at 11:35 AM CNAs A and B were asked when they were supposed to wash their hands, CNA A stated before and after care. CNA B nodded her head in agreement. CNAs A and B were asked at what other times were they supposed to wash their hands and CNA A stated if gloves were visibly dirty and each time they removed their gloves and CNA B nodded her head in agreement. When asked why CNA A had not washed her hands before leaving the room (to retrieve clean linens) CNA A stated she had washed them in the shower room, when she went to get the clean linen. In an interview on 09/18/20 at 12:30 PM the DON stated they were conducting a one to one in-service on handwashing with CNAs A & B. She stated she told them they needed to wash their hands before they left a resident's room and when they returned to the room before resuming care. Review of an in-service, dated 09/18/20, revealed, Peri care/Handwashing prior to entering room and upon exiting even if not providing care and helping reposition a resident/infection control. There was a separate sign in sheet for CNA A and CNA B for this in-service. Review of the facility's policy and procedure titled Perineal Care, revised May 2007, revealed the following: Procedures: 1. Use a screen for resident privacy 4. Gather necessary equipment. 5. Wash hands properly. Review of the facility's policy and procedure titled Hand Washing, dated June 2016, revealed, It is the policy of this community to cleanse hands to prevent transmission of possible infectious material and to provide a clean, healthy environment for residents and staff. Hand washing is considered the most important single procedure for preventing the spread of infections. 2. Review of Resident #2's admission record, dated 09/28/20, revealed he was a [AGE] year-old male admitted to the facility on [DATE]. Resident #2 had [DIAGNOSES REDACTED]. Observation on 09/18/20 at 11:42 AM on the presumptive COVID-19 positive hall, with the DON, revealed LVN C was in Resident #2's room without an isolation gown on. She was leaning towards the resident and talking to him. When LVN C came out of the room the surveyor asked why she had not put a gown on and she stated she was just in the room answering the resident's call light. The DON replied to LVN C that she had to put on an isolation gown every time she went into a presumptive COVID-19 positive room. 3. Review of Resident #3's admission record, dated 09/28/20, revealed she was a [AGE] year-old female admitted to the facility on [DATE]. Resident #3 had [DIAGNOSES REDACTED]. Observation on 09/18/20 at 11:45 AM on the presumptive COVID-19 positive hall revealed the DON standing outside of Resident #3's room and when she walked up to room, observed CNA D in the room and she had no isolation gown on. After CNA D washed her hands the CNA came out of the room, and the DON stopped her, and confronted her about not having an isolation gown on. During an interview on 09/18/20 at 12:30 PM the DON stated LVN C and CNA D were both getting written up for not having isolation gown's on while in a presumptive COVID-19 positive resident's room. She stated they had conducted a one to one in-service with both staff with return demonstrations of PPE use. She stated they were also conducting a one to one in-service on handwashing as well with CNAs A & B. She stated she told them they needed to wash their hands before they left a resident's room and when they returned to the room before resuming care. Review of a facility in-service , Gowns, PPE in Warm (Presumptive COVID-19 Positive) Hall, dated 09/18/20, revealed All PPE, Gowns, Gloves, face shield or goggles must be worn anytime entering a room on the warm (presumptive COVID-19 Positive) hall. There was a separate sign in sheet for LVN C and CNA D for this in-service. Review of the facilities policy and procedure for Infectious Disease Outbreak Prevention, Investigation, & Procedures, undated, revealed: 5. Institute Control and Prevention Measures Controls may include isolating individuals who are ill from those who are not ill .and using personal protective equipment (PPE) such as masks, gowns, gloves, etc. . 6. Educate Staff, Residents and Visitors .Reinforce the importance of handwashing and proper personal protective equipment use for all.

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.