STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455968	A. BUILDING _____ B. WING _____	**06/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GRAHAM OAKS CARE CENTER	**1325 FIRST ST GRAHAM, TX 76450**

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 observation, interview and record review the facility failed to maintain an infection control program designed to prevent the development and transmission for 2 of 13 residents (Resident #1 and #2) reviewed for infection control in that: 1. RT #1 let the open tip of the green and white suction box touch the blanket when she performed [MEDICAL CONDITION] suction care for Resident #1. 2. RT #1 placed her used gloves in the side pocket of her scrub pants before she left Resident #1's room. 3. RT #2 did not clean the entrance tip used to insert the medication before or after he performed [MEDICAL CONDITION] suction care for Resident #2. This deficient practice placed residents at risk for cross contamination which could result in infection. The findings were: 1. Review of Resident #1's Face Sheet, dated, 6/13/2020, revealed an admission date of [DATE], with the [DIAGNOSES REDACTED]. Review of the most current MDS, dated [DATE], revealed a BIMS score of 15 for Resident #1, which indicated he was cognitively intact. Review of Resident #1's physician's orders [REDACTED]. Observation during suctioning care, of Resident #1, on 6/12/2020 at 3:15 PM, revealed RT #1 placed the uncapped suction box tip on the blanket, which could have contaminated the open entrance point to the suction tubing connected to the resident's skin and lungs, which could have placed Resident #1 at risk for an in-facility (nosocomial) infection. After suctioning Resident #1, RT #1 then placed the gloves she used for this procedure into an open pocket of her scrub pants instead of disposing them properly into a concealed clear trash bag before she exited Resident #1's room. In an interview, on 6/12/2020 at 3:20 PM, with Resident #1, he stated my blanket is changed every other day. During an interview with RT #1, on 6/12/2020 at 3:25 PM, she revealed that she did not clean the tip every time, did not know of a policy that stated this, and stated she was told they could not dispose of used gloves in the resident's trash receptacle. Review of RT #1's Skills Checklist dated 4/2019, documented she had been trained on the skillset for [MEDICAL CONDITION] Care and Suction Care. 2. Review or Resident #2's Face Sheet, dated 6/13/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of the Admission MDS, dated [DATE], revealed Resident #2 had a BIMS score of 0 out of 15. Review of Resident #2's physician's orders [REDACTED]. Observation of suction care on Resident #2, on 6/13/2000 at 4:00 PM, the RT #2 did not clean the tip of the entrance port before or after he inserted the Sodium Chloride 0.09% vial. During an interview with the RT supervisor, on 6/12/2020 at 3:30 PM, he revealed he could not produce a current infection control policy that required the RT's to clean the tips of the suction entrance areas when the RT's performed [MEDICAL CONDITION] care, and the policy did not include a technique to clean the tips of the entrance ports before or after suction care. The policy included to make another bag for contaminated waste. During an interview with RT #2, he stated he received a skills checkoff when he started his job a few years ago. He stated he was not aware of policy to clean the medication entrance port the suction tubing, and stated he did not routinely clean the entrance site to the port in the 4 years he had worked at the facility. Review of RT's Skills Checklist dated 4/2019, revealed this was the latest skills checklist for the RT department and had included [MEDICAL CONDITION] and Suction Care for RT #1 and RT #2. During an interview on 6/13/2020 at 2:30 PM, with the DON, she revealed all staff should attend quarterly Quality Assessment meeting, follow infection control procedures, and have specific policies for the Respiratory Department which addressed Infection Control. The policy provided by the RT supervisor, dated April 2019, and titled [MEDICAL CONDITION] Care, stated (in part): 3. Gather all new clean or sterile equipment needed and place in a clean plastic bag, also make available another plastic bag for contaminated waste.

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.