STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675139	A. BUILDING _____ B. WING _____	04/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR HEALTHCARE RESIDENCE	1025 W YEAGUA GROESBECK, TX 76642

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 and prevention control program that included, at a minimum, a system for preventing and controlling infections for 3 of 3 residents reviewed for infection control. (Resident #1, Resident #2, and Resident #3) A. CNA A and CNA B failed to use appropriate hand hygiene while providing incontinence care for Resident #1. B. LVN C failed to provide wound care using appropriate infection control measures for Resident #1. C. LVN C failed to properly sanitize a multi-use glucometer (per manufactures instructions) between uses for Resident #2 and Resident #3. This deficient practice placed residents requiring incontinence care, wound care, and blood glucose monitoring at risk for cross-contamination and spread of infection and blood-borne infections. Findings Include: A. Review of Resident #1's face sheet reflected an [AGE] year-old female who was admitted to the facility on [DATE] with diagnoses, including dysphagia [MEDICAL CONDITION], muscle wasting, and a coccyx pressure ulcer stage 3. A review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 6, which indicated severe cognitive impact. A review of Resident #1's care plan dated 3/22/20 reflected Resident #1 was dependent on staff for all ADLs and required the support of two staff members for bed mobility, transfers, and incontinent care. Resident #1 was incontinent of bowel and bladder and monitoring needed for incontinence care every two hours and PRN. During an observation on 4/8/20 at 10:25 am CNA A and CNA B washed their hands and donned gloves. CNA A then cleansed Resident #1's perineal area, cleaning front to back using a clean wipe to clean each area. CNA B assisted the resident in turning to the left side; afterward, CNA A cleansed the resident's rectal and buttock using a clean wipe to clean each area, wiping in a bottom to top direction touching the outside of the package of wipes with the soiled wipe. CNA B took a clean brief off of the resident's bed linens and placed it under the resident's right leg while holding resident's right hip. CNA A then assisted the resident in turning to the left side while CNA B pulled the clean brief under the resident's buttock. Then both CNA A and CNA B assisted the resident to a comfortable position. CNA A took off her gloves and applied one glove to her left hand. Then CNA A took the trash bag with soiled linens and left the room without washing or sanitizing her hands. CNA A returned to the resident's room and took the same package of wipes she used to provide incontinence care to the resident and left the room without washing or sanitizing her hands. CNA B took off her gloves and left the room without washing or sanitizing her hands. In an interview on 4/8/20 at 10:40 am, CNA A stated she was supposed to wash or sanitize her hands before and after performing incontinence care. CNA A stated she did use a hand sanitizer located at the nursing station after she threw the soiled trash away. CNA A stated she did not know she should have washed her hands before leaving Resident #1's room. CNA A stated she did not think she was supposed to wash her hands with soap and water after coming into contact with fecal matter. CNA A stated she had an in-service on handwashing, but it was a long time ago. CNA A stated hand washing after touching a soiled brief and before leaving a resident's room was important to prevent cross-contamination. During an interview with CNA B on 4/8/20 at 10:45 am. CNA B stated she was not aware she needed to wash her hands before leaving the room. CNA B also stated it was important to wash her hands to prevent the spread of germs. During an observation on 4/8/20 at 10:28 am, LVN C provided wound care at the same time as CNA A, and CNA B provided incontinence care for Resident #1. LVN C prepared supplies, placing them on a bedside table with a dried white substance on the surface. CNA A and CNA B assisted the resident to a right side-lying position while LVN C removed dressing to the coccyx, which was saturated with a reddish tinged drainage. LVN C placed the soiled dressing in the trash bin. LVN C then cleaned the resident's wound with normal saline and gauze. LVN C pressed against the wound bed then threw used gauze into the trash bin. LVN C then applied ordered medication to the resident's wound using her gloved finger, wearing the same gloves she wore which touched Resident's soiled dressing. LVN C then disposed of used dressing supplies in the resident's trash bin, failing to use a red biohazard bag. LVN C removed her gloves and performed hand hygiene and left the room. In an interview conducted on 4/8/20 at 10:32, LVN C stated she thought the white dried substance on the bedside table was residue from the housekeeping staff. LVN C said she thought she saw the housekeeping staff was just cleaning in Resident #1's room. In an observation on 4/8/20 at 10:35 am housekeeping staff entered Resident #1's room. In an interview at 10:35 am, housekeeping staff stated she had not previously cleaned Resident #1's room that day (4/8/20). In an interview on 4/8/20 at 2:00 pm, LVN C stated she was not sure she should have washed her hands after she took off Resident #1's soiled dressing. She stated she remembered not sanitizing the bedside table, and she should have but said she did not have sanitizing wipes on her cart. LVN C stated she did use her gloved finger to apply medication to Resident #1's coccyx wound because the medication fell off the applicator, and she did not want to waste it. LVN C stated she also knew she should have sanitized the multi-use glucometer with an EPA approved disinfectant agent but said she did not have access to EPA approved disinfecting wipes. Review of Resident #2's face sheet reflected a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's MDS dated [DATE] reflected Resident #2 has a moderately impaired cognitive pattern. Review of Resident #2's care plan dated 1/27/20 reflected Resident #2 is dependent on staff for ADLs and requires limited assistance with bathing and transfers. Resident #2 is also at risk for unstable blood sugars (glucose) related to Type 2 Diabetes. Review of Resident #3's reflected a [AGE] year-old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #3's MDS dated [DATE] reflected Resident #3 has a BIMS score of 7, which indicated severe cognitive impact. Review of Resident #3's care plan dated 2/16/20 reflected Resident #3 is dependent on staff for ADLs and bathing and is at risk for unstable blood sugars related to Type 1 Diabetes. During an observation on 4/8/20 at 11:00 am LVN C performed a blood sugar check for Resident #2 and Resident #3. LVN C performed hand hygiene and applied gloves. LVN C then wiped glucometer with a 70% [MEDICATION NAME] Alcohol wipe and prepared supplies. LVN C entered the Resident's room, holding the supplies in her gloved hand; she then placed the glucometer on top of the Resident's bed linens. LVN C then performed a blood glucose check, picked up the used supplies, and left the room. LVN C then placed used supplies, glucometer, as well as the lancet used to check Resident #2's blood sugar on top of the treatment cart. LVN C then placed the used supplies and disposed of them in the trash bin and sharps container, removed her gloves, and sanitized her hands. LVN C wiped glucometer with a 70% [MEDICATION NAME] Alcohol wipe and sanitized her hands. Then she prepared supplies and donned gloves. LVN C entered Resident #3's room and placed the glucometer on the armrest of the Resident's recliner. Then she performed a blood glucose test; afterward, she left the room taking the used supplies, including the lancet used to check the Resident's blood sugar as well as the glucometer and placing them on top of her treatment cart. After that, she wiped the glucometer with a 70% [MEDICATION NAME] Alcohol prep pad and put the glucometer in the top drawer of the treatment cart. In conclusion, the LVN disposed of used supplies in a trash bin, and the used lancet in the sharps container removed her gloves and sanitized her hands. During an observation on 4/8/20 at 11:30 am revealed LVN C's treatment cart did not contain EPA approved sanitizing wipes. During an interview conducted on 4/8/20 at 2:00 pm LVN C stated I do remember placing the glucometer on Resident #2's bed linens and Resident # 3's recliner. However, at the time, I was not aware I was cross-contaminating. I guess I have just have become complacent. LVN stated she did remember putting used supplies, including a used lancet on the surface of her treatment cart. LVN C stated she also knew she should have

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675139	A. BUILDING _____ B. WING _____	**04/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR HEALTHCARE RESIDENCE	**1025 W YEAGUA GROESBECK, TX 76642**

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	(continued... from page 1) sanitized the multi-use glucometer with an EPA approved disinfectant agent but said she did not have access to EPA approved disinfecting wipes. LVN C stated she should have washed her hands to decrease the risk of cross-contamination. LVN C stated she should have sanitized the bedside table before placing supplies on its' surface to reduce the risk of cross-contamination. In an interview conducted on 4/8/20 at 12:35 pm, the DON stated when staff performs peri-care, they should always wash their hands before they start, when they go from a contaminated area to a clean area, and before they leave a residents' room. Facility staff should also sanitize the bedside table before placing clean supplies on its surface. Facility staff should also wash their hands with soap and water after coming into contact with contaminated body fluids and or fecal matter. DON stated facility staff should never use their soiled gloved finger to apply medication to a wound bed. DON stated medication should be applied to the wound with an applicator DON stated soiled wound dressing supplies should be discarded in a red biohazard bag. DON stated the glucometer should be cleaned with Santi-Wipes (EPA Approved), which are available at the nurses' station. DON said when the staff performs blood sugar monitoring, they should not place the glucometer on the surface of the bed or Resident's chair. The nurse should sanitize the glucometer with a Santi-wipe before placing the glucometer on top of the treatment cart. The DON stated used items utilized to perform blood sugar checks should never be placed on top of the treatment cart but should be discarded right after use. Review of facility policy dated 2010 reflected hand washing should occur after coming in contact with mucous membranes, body fluids, or secretions. Review of Lippincott's fundamentals of nursing practice (pg. 725) reflected the following elements: Hand hygiene should be performed with soap and water and or hand sanitizer after moving from a contaminated-body site to a clean body site during patient care; after contact with body fluids, excretions, mucous membranes, non-intact skin, or wound dressings (if hands aren't visibly soiled); after removing gloves; and after contact with inanimate objects in the patient's environment. A Review of the Texas Curriculum for Nurse Aides in Long Term Care Facilities, Personal Care Skills, page 106-107 reflected the following elements: A. Purpose: To clean the female perineum without contaminating the urethral area with germs from the rectal area. 1. Beginning Steps a. Wash hands . 10. Gently wash, rinse and dry the rectal area and buttocks, wiping from the base of labia downward over the rectal area until the entire area is clean, soap-free, and dry . 11. Closing steps . b. Remove and discard gloves following facility policy at the appropriate time to avoid environmentally Contamination. Wash hands . Record review of the facilities policy for disinfecting reflected Assure Prism multi-use blood glucose monitoring system reflected the glucometer should be cleaned and disinfected with an EPA approved disinfect before and after use.