STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676402	A. BUILDING _____ B. WING _____	**04/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDEMERE AT WESTOVER HILLS	**11106 CHRISTUS HILLS SAN ANTONIO, TX 78251**

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 develop and implement ongoing infection prevention and control for 6 of 10 residents reviewed for medication pass and wound care (Resident #1, #2, #3, #4, #5 and #6), in that: 1. LVN A did not perform hand hygiene after touching contaminated surfaces and objects before returning to prepare and provide medications for Resident #1, #2, #3, #4 and #5. 2. LVN B did not perform hand hygiene after touching contaminated objects before returning to preparation and provision of wound care for Resident #6. These deficient practices could place residents who receive wound care and medications at risk for cross contamination and/or spread of infection. The findings were: Record review of Resident # 1's face sheet revealed Resident # 1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 2's face sheet revealed Resident # 2 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 3's face sheet revealed Resident # 3 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 4's face sheet revealed Resident # 4 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 5's face sheet revealed Resident # 5 was admitted on [DATE] with [DIAGNOSES REDACTED]. Observation on 4/9/20 at 12:54 pm revealed LVN A touched a keyboard on top of the med cart and then gathered three medication cups and prepared medication for Resident # 1 without performing hand hygiene. LVN A proceeded to hold the water glass on top of the medication cup, wrapping her fingers around the entire medication cup. Observation on 4/9/20 at 12:55 pm revealed LVN A provided the medication to Resident # 1 and the medication cup and water cup touched Resident # 1's mouth. Observation on 4/9/20 at 12:57 pm revealed LVN A did not perform hand hygiene after exiting Resident # 1's room. LVN A proceeded to crush Resident # 2's [MEDICATION NAME] capsule in a plastic bag. LVN A then touched a thermometer in an open drawer on the side of the medication cart at 12:58 pm. LVN A took a plastic cup of spoons from another staff member. Observation on 4/9/20 at 12:59 pm revealed LVN A mixed the crushed [MEDICATION NAME] capsule with pudding while outside Resident # 2's room. Observation on 4/9/20 at 1:01 pm revealed LVN A entered Resident # 2's room without performing hand hygiene and provided the medication and water to Resident # 2. Observation on 4/9/20 at 1:07 pm revealed LVN A prepared Resident # 3's medications in capsule form and placed the capsules in a medication cup. LVN A proceeded to touch a white binder and two pens. During an interview on 4/9/20 at 1:09 pm, LVN A stated she was writing down in the white binder how many controlled medications she had left for Resident # 3. Observation on 4/9/20 at 1:09 pm revealed LVN A touched the black pen again. LVN A proceeded to hold the water glass on top of the medication cup, wrapping her fingers around the medication cup. Observation on 4/9/20 at 1:09 pm revealed LVN A walked into the Resident # 3's room without performing hand hygiene and provided the medication cup to Resident # 3. Resident # 3 proceeded to place the medication cup to her lips and drank water from the plastic cup. Observation on 4/9/20 at 1:15 pm revealed LVN A moved the medication cart to Resident # 4's room and touched the mouse, keyboard, and paper on top of the medication cart. LVN A unlocked the cart and prepared the medication for Resident # 4 by placing the capsule in a medication cup, gathered an empty plastic cup and filled it with water, without performing hand hygiene. LVN A placed the medication cup below the water cup, wrapping her fingers around the medication cup, and entered Resident # 4's room and provided the medication to Resident # 4. Resident # 4 placed the medication cup to her lips and drank from the cup of water. Observation on 4/9/20 at 1:24 pm revealed LVN A touched the medication cart, mouse, keyboard, and papers, then opened the medication cart drawer and got out a capsule for Resident # 5. LVN A poured water into the plastic water cup and placed the medication cup under the water cup in her hands, wrapping her fingers around the medication cup. LVN A provided the medication to Resident # 5 and Resident # 5 placed the medication cup to her lips and drank from the water cup. During an interview on 4/9/20 at 1:41 pm, LVN A stated she does sometimes forget to perform hand hygiene right before entering the resident's room. During an interview on 4/9/20 at 5:50 pm, the DON acknowledged that staff should perform hand hygiene after touching contaminated objects. Record review of a facility policy titled, Handwashing, from Nursing Policy and Procedures, Infection Control Program Section 15, page 74, reviewed and revised March 2019, revealed that hand washing is the single most important means of preventing the spread of infection, hand sanitizing gel may be used in place of soap and water, and hand hygiene should be performed after patient contact. Record review of a policy titled, Medications, from Patient Care Management Systems, dated November 2017, did not mention policy or procedure for hand hygiene during medication pass. 2. Record review of Resident # 6's Face Sheet revealed that Resident # 6 was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 6 Physician order [REDACTED]. Record review of Resident # 6 Physician order [REDACTED]. During an interview on 4/9/20 at 3:00 pm, LVN B stated she was the Wound Care Nurse and that she was going to provide wound care for Resident # 6's stage II pressure ulcers to left and right heels. Observation on 4/9/20 at 3:01 pm revealed LVN B entered Resident # 6's room and introduced herself and then, washed her hands in Resident # 6's bathroom. Observation on 4/9/20 at 3:02 pm revealed LVN B turned on the light switch to Resident # 6's room, which is located on the wall on the inside of the room, next to the door. LVN B proceeded to open the wound care supply cart drawer, which was located just outside Resident # 6's door, in the hall and placed a piece of wax paper down on the top of the cart. LVN B then placed her supplies for wound cleaning on top of the wax paper. LVN B brought all supplies wrapped in the wax paper into Resident # 6's room, without washing her hands. LVN B donned gloves. Observation on 4/9/20 at 3:05 pm revealed LVN B took Resident # 6's socks off and wet the gauze with saline, then patted the wound, without performing hand hygiene. During an interview on 4/9/20 at 3:30 pm, LVN B acknowledged that she should have performed hand hygiene after turning on Resident # 6's room light before proceeding with wound care. During an interview on 4/9/20 at 5:50 pm, the DON acknowledged that staff should perform hand hygiene after touching contaminated objects. Record review of a facility policy titled, Handwashing, from Nursing Policy and Procedures, Infection Control Program Section 15, page 74, reviewed and revised March 2019, revealed that hand washing is the single most important means of preventing the spread of infection, hand sanitizing gel may be used in place of soap and water, and hand hygiene should be performed after patient contact. Record review of a facility policy, titled, Skin and Wound Treatment, Patient Care Management Systems, Protocol 1-B, dated November 2017, does not discuss the procedure of hand hygiene during wound care.

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.