STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676392	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGEND OAKS HEALTHCARE AND REHABILITATION - NEW BR	**2468 FM 1101 NEW BRAUNFELS, TX 78130**

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 prevention and control program, including hand hygiene, designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for 1 of 1 Halls observed for infection control practices, in that; CNA D did not wash or sanitize hands before entering two resident rooms in hall 600. This failure could place residents at risk for infections. The findings were: Observation of Hall 600 on 3/11/2020 at 9:14 a.m., revealed CNA D exited Bedroom [ROOM NUMBER] with a clipboard in his hands. CNA D then walked across the hall and did not wash or sanitize his hands prior to entering Bedroom [ROOM NUMBER]. CNA D then exited Bedroom [ROOM NUMBER] and did not wash his hands. CNA D walked across the hall and entered Bedroom [ROOM NUMBER]. CNA D did not wash or sanitize his hands prior to entering Bedroom [ROOM NUMBER]. Interview with CNA D at 3/11/2020 at 9:15 a.m. confirmed he had not washed or sanitized his hands prior to entering Bedrooms #603, #604 and #605 when checking on resident's meal tickets. Interview with LVN C on 3/11/2020 at 9:15 a.m. confirmed that staff are expected to wash hands upon entering and exiting resident rooms. Interview with ADON B on 3/11/2020 at 9:21 a.m. stated that all staff are expected to wash or sanitize their hands upon entering and exiting resident's rooms. Interview on 3/11/2020 at 12:39 p.m., with the DON, she stated that all staff are expected to wash or sanitize their hands when going in and out of resident's rooms. Review of the facility policy Hand Hygiene undated, revealed in part . the facility considers hand hygiene the primary means to prevent the spread of infections.

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.