STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676228	A. BUILDING _____ B. WING _____	**04/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KENDALL HOUSE WELLNESS & REHABILITATION	**1050 GRAND BLVD. BOERNE, TX 78006**

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 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 3 of 3 residents (Residents #1, #2, and #3) reviewed for infection control, in that: 1. a. LVN A exited Resident #1's room without removing soiled gloves and washing or sanitizing her hands after performing blood sugar check for Resident #1. b. LVN A exited Resident #1's room without removing soiled gloves and washing or sanitizing her hands after administering Resident #1's insulin injection. 2. Resident #2's vent next to the filter door in the back of the oxygen concentrator was filled with a gray layer of substance. 3. Resident #3's vent next to the filter door in the back of the oxygen concentrator was filled with a gray layer of substance. These deficient practices could place residents in the facility who received insulin and residents on oxygen therapy at risk for infection. The findings were: 1a. Record review of Resident #1's admission record dated 4/7/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's physician order [REDACTED].#1 had an order for [REDACTED].= 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units; 350 - 399 = 5 units; 400+ = 6 units Notify MD if >400, subcutaneously before meals and at bedtime for diabetes mellitus start date 3/24/2020. Observation on 4/7/2020 at 11:46 AM revealed LVN A exited Resident #1's room without removing soiled gloves and washing or sanitizing her hands after LVN A checked Resident #1's blood sugar. Further observation revealed LVN A wore her soiled gloves walked toward the medication cart to discard lancet and blood glucose strip used to check Resident #1's blood sugar. Observation on 4/7/2020 at 11:51 AM revealed LVN A exited Resident #1's room without removing her soiled gloves and washing or sanitizing her hands after LVN A administered Resident #1's insulin injection. Further observation revealed LVN A removed her soiled gloves at her medication cart after she discarded the insulin needle in the sharp container. Record review of Resident #1 treatment record dated 4/7/2020 revealed Resident #1's blood sugar on 4/7/2020 at 11:30 AM was documented as 179 and received 1 unit of Humalog Solution 100 UNIT/ML (Insulin [MEDICATION NAME]) Inject as per sliding scale. In an interview on 04/07/2020 at 11:54 AM, LVN A confirmed she did not remove her soiled gloves or washed or sanitized her hands before exiting Resident#1's room. She further confirmed she wore her soiled gloves to discard blood glucose strip and lancet in the medication cart's sharp container. In an interview on 04/07/2020 at 11:55 AM, LVN A confirmed she did not discard her gloves and wash or sanitize her hands before exiting Resident#1's room and after giving Resident #1's insulin injection. LVN A further confirmed she wore the soiled gloves to bring the insulin pen and needle to the medication cart to discard the needle into the sharp container. In an interview on 04/07/2020 at 4:16 PM, the DON confirmed LVN A should have removed her soiled gloves prior to exiting Resident #1's room after checking Resident #1's blood sugar and administering insulin. The DON further confirmed LVN A should have removed her soiled gloves and washed or sanitized her hands before exiting Resident #1's room. Record review of the facility's policy titled Standard Precaution dated 3/2020 revealed 2. Gloves . g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. 2. Record review of Resident #2's admission record dated 4/7/2020 revealed an original admission date of [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's physician order [REDACTED].#2 had an order for [REDACTED]. Observation on 4/7/2020 at 9:57 AM revealed Resident #2 was wearing a nasal cannula, and Resident #2's oxygen concentrator was set at 3.5 liter per minutes. Further observation revealed the vent next to the filter door in the back of Resident #2's oxygen concentrator was filled with a gray layer of substance. In an interview on 4/7/2020 at 11:36 AM, LVN B confirmed the vent on the back of Resident #2's oxygen concentrator was filled with a layer of gray substance. 3. Record review of Resident #3's admission record dated 4/7/2020 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #3's physician order [REDACTED].#3 had an order for [REDACTED]. With start date 2/16/2020. Observation on 4/7/2020 at 11:21 AM revealed the vent next to the filter door in the back of Resident #3's oxygen concentrator was filled with a layer of gray substance. In an interview on 4/7/2020 at 11:37 AM, LVN B confirmed the vent next to the filter door in the back of Resident #3's oxygen concentrator was filled with a layer of gray substance. In an interview 4/07/2020 at 4:15 PM, the DON stated the licensed nurse should have cleaned the vent in the back of the oxygen concentrator when the license nurse changed oxygen tubing and humidifier every Sunday. Record review of oxygen concentrator user manual undated revealed for proper operation, your concentrator requires unobstructed ventilation.

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.