STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676063	A. BUILDING _____ B. WING _____	**07/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALFREDO GONZALEZ TEXAS STATE VETERANS HOME	**301 E YUMA AVE MCALLEN, TX 78503**

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, designed to provide a safe, sanitary and comfortable environment, and to prevent the development and transmission of communicable disease and infections for two Residents (R#1 and R#3) of three residents observed for infection control procedures. -RN A failed to use gloves when administering Resident (R) #1's insulin. -LVN B did not clean the vital sign machine after taking R#2's vital signs. LVN B grabbed the blood pressure cuff from the same machine to take R#3's blood pressure, without first cleaning it. LVN B cleaned the machine after surveyor intervened. -LVN D did not wear an N-95 mask correctly while in the COVID-19 unit. -CNA C failed to utilize the disinfectant (Oxivir) per manufacturer's guidelines. -HK E went from the dirty to clean area without taking the proper precautions. HK E was using the same gloves to clean the rooms in the COVID unit. HK E was not wearing the KN-95 mask correctly while in the COVID unit. These failures could affect residents dependent upon care and place them at risk for healthcare associated cross contamination, infections, and COVID-19. Findings included: 1) Record review of R#1's face sheet, dated 07/24/20, revealed R#1 was an [AGE] year-old male who was admitted to the facility on [DATE]. R#1's [DIAGNOSES REDACTED]. Record review of R#1's Quarterly MDS assessment revealed R#1: -had adequate hearing, -had clear speech, -was able to make himself understood, and -was able to understand others. Observation on 07/23/20 at 12:32 p.m. revealed RN A administered insulin to R#1's abdomen, without wearing gloves. In an interview at the time of observation, RN A said she was not sure if she had to wear gloves or not when administering insulin. RN A said she normally administered insulin without gloves. In an interview on 07/23/20 at 2:12 p.m., the DON said staff were to wear gloves when administering any injection, for infection control. 2) Record review of R#2's face sheet, dated 07/27/20, revealed R#2 was a [AGE] year-old male who was admitted to the facility on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's Quarterly MDS assessment, dated 07/08/20, revealed R#2: -had difficult hearing (minimal), -had clear speech, -had adequate vision -was usually understood by others, and -was usually able to understand others. Record review of R#3's face sheet, dated 07/27/20, revealed R#3 was an [AGE] year-old male who was admitted to the facility on [DATE]. R#3's [DIAGNOSES REDACTED]. Record review of R#3's Quarterly MDS assessment, dated 05/30/20, revealed R#3: -had adequate hearing, -had clear speech, -had adequate vision with corrective lenses, -was able to make himself understood, and -was able to understand others. Observation on 07/23/20 at 1:32 p.m. revealed LVN B checked R#2's vital signs (blood pressure, pulse, temperature and oxygen saturation levels) with a vital sign machine, and left the room. LVN B did not clean the vital sign machine and walked to R#3's room. LVN B explained to R#3 that vital signs would be checked and grabbed the blood pressure cuff to take R#3's blood pressure. At this time, surveyor asked LVN B to clean the vital sign machine prior to taking R#3 vital signs. In an interview, at the time of the observation, LVN B, said she forgot to clean the vital sign machine, but knew she was to clean it after each resident use. In an interview, on 07/23/20 at 2:12 p.m., the DON said staff were to clean the vital sign machine before and after using it. 3) Observation on the 600 Hall (hall housing COVID-19 positive residents), on 07/23/20 at 2:33 p.m., revealed LVN D was observed wearing a surgical mask, an N-95 mask over the surgical mask, and another surgical mask over the N-95 (three masks). In an interview on 07/27/20, LVN D said she was not aware she was not to wear the surgical mask underneath the N-95. LVN D said she now understood that the N-95 did not create a tight seal around the face when a surgical mask was worn underneath it. In an interview on 07/23/20 at 4:07 p.m., Administrator said all staff were trained on how to don PPE. 4) Observation down the hall housing COVID-19 positive residents, on 07/23/20 at 2:27 p.m., revealed CNA C walking out of a resident's room, and spraying down the vital sign machine from bottom to top with Oxivir disinfectant and immediately wiping it down with sani-cloth wipes. CNA C did not wait a full minute to allow the disinfectant to dry. Record review of Oxivir TB Manufacturer's Label revealed: 2. All surfaces must remain visibly wet for 1 minute for viruses and bacteria . 3. Allow to air dry. In an interview, at the time of the observation, CNA C said she was unsure how long to leave the disinfectant on the vital sign machine. In an interview, on 07/23/20 at 3:15 p.m., the DON said staff knew to look at the label for any disinfectant, to know how long the contact time was. 5) Observation on Hall 700 (hall housing COVID-19 positive residents), on 07/23/20 at 3:29 p.m., revealed HK E walking out of a resident's room with cleaning supplies. HK E had on coveralls and gloves. CNA G asked HK E for a bag from the donning area. HK E proceeded to walk into the donning area, which had a sign reading Do Not Enter. HK E was observed wearing coveralls, black gloves, and a loose fitting KN-95 mask. In an interview, at the time of the observation, LVN F said that HK E was not to walk into the donning area with the gloves and coveralls on. LVN F said HK E should be wearing a fitted N-95 mask, not the loose KN-95 mask. In an interview, on 07/23/20 at 3:38 p.m., HK E said he was unaware that he was not to go into the donning area with the coveralls and gloves on. HK E said he had not been changing his gloves between cleaning each room. HK E said he did not know he had to change gloves between cleaning each room, he was just told the gloves were special gloves. In an interview, on 07/23/20 at 4:07 p.m., the Administrator said a Manager from housekeeping trained the new housekeeping staff. The Administrator said HK E would be coached, and removed from the COVID hallway. The Administrator said there was an RN who fitted the staff for N-95 masks. Record review of facility policy titled Administering Medications revised December 2012, revealed: Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Record review of facility policy titled Checklist for Nursing Homes in COVID-19 Hotspots, dated 07/01/20, revealed: Personal Protective Equipment: Ensure adequate supply and that all staff are properly trained to use PPE.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE