STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676297	A. BUILDING _____ B. WING _____	**10/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE RIO AT MISSION TRAILS	**6211 S NEW BRAUNFELS AVE SAN ANTONIO, TX 78223**

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 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 1 RN (RN A) and 1 LVN (LVN B) were able to demonstrate competency in skills and techniques for 1 of 2 residents (Resident #10) observed for care and infection control, in that: 1. a. While providing wound care for Resident #10, RN A did not sanitize or wash her hands between changing her gloves, after cleaning the wound and before applying the treatment and dressing. b. While providing wound care for Resident #10, RN A and LVN B did not change their gloves or wash their hands after touching Resident #10 soiled briefs and before touching the clean briefs. These deficient practices could place residents who receive assistance with care at risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident #10's face sheet, dated 10/01/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #10's Admission MDS, dated [DATE], revealed the resident had severe cognitive impairment, was occasionally incontinent of bowel, had an indwelling catheter, and had an unstageable pressure ulcer. Record review of Resident #10's active physician orders [REDACTED]. One time a day every Mon, Wed, Fri, with a start date of 09/30/2020. Observation on 10/01/2020 at 11:40 a.m. of wound care for Resident #10's Stage 3 pressure wound to coccyx revealed RN A did not sanitize or wash her hands between changing her gloves after cleaning the resident's wounds and before applying the treatment and placement of a new dressing. Further observation revealed RN A and LVN B did not change their gloves or wash their hands after touching Resident #10 soiled with blood briefs and before touching the clean briefs. During an interview with RN A and LVN B on 10/01/2020 at 12:00 p.m., RN A confirmed she did not sanitize or wash her hands between changing her gloves after cleaning Resident #10's wounds and before applying the treatment and placement of a new dressing. RN A and LVN B confirmed they did not change their gloves or wash their hands after touching Resident #10 soiled with blood briefs and before touching the clean briefs. Record review of nursing agency's policy titled, Annual Training and Orientation Mandatory, dated 07/24/2020, revealed RN A passed the skills competency for infection control and hand washing. Record review of facility's document titled, Licensed Nurse Proficiency Audit, dated 08/05/2020, revealed LVN B passed the skills competency for infection control and hand washing. During an interview with the Administrator and Regional Nurse on 10/01/2020 at 12:30 p.m., the Administrator and Regional Nurse confirmed staff should sanitize their hands between change of gloves and should change gloves and sanitize their hands when going from dirty to clean. Record review of the facility's policy titled, Fundamental of Infection Control Precautions, dated 2019, revealed: The following is a list of some situations that require hand hygiene . after contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressings, bedpans . After removing gloves.
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 Control Program designed to help prevent the development and transmission of infections for 1 of 2 residents (Resident #10) observed for infection control, in that: 1. a. While providing wound care for Resident #10, RN A did not sanitize or wash her hands between changing her gloves, after cleaning the wound and before applying the treatment and dressing. b. While providing wound care for Resident #10, RN A and LVN B did not change their gloves or wash their hands after touching Resident #10 soiled briefs and before touching the clean briefs. These deficient practices could place residents who receive assistance with care at risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident #10's face sheet, dated 10/01/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #10's Admission MDS, dated [DATE], revealed the resident had severe cognitive impairment, was occasionally incontinent of bowel, had an indwelling catheter, and had an unstageable pressure ulcer. Record review of Resident #10's active physician orders [REDACTED]. One time a day every Mon, Wed, Fri, with a start date of 09/30/2020. Observation on 10/01/2020 at 11:40 a.m. of wound care for Resident #10's Stage 3 pressure wound to coccyx revealed RN A did not sanitize or wash her hands between changing her gloves after cleaning the resident's wounds and before applying the treatment and placement of a new dressing. Further observation revealed RN A and LVN B did not change their gloves or wash their hands after touching Resident #10 soiled with blood briefs and before touching the clean briefs. During an interview with RN A and LVN B on 10/01/2020 at 12:00 p.m., RN A confirmed she did not sanitize or wash her hands between changing her gloves after cleaning Resident #10's wounds and before applying the treatment and placement of a new dressing. RN A and LVN B confirmed they did not change their gloves or wash their hands after touching Resident #10 soiled with blood briefs and before touching the clean briefs. During an interview with the Administrator and Regional Nurse on 10/01/2020 at 12:30 p.m., the Administrator and Regional Nurse confirmed staff should sanitize their hands between change of gloves and should change gloves and sanitize their hands when going from dirty to clean. Record review of the facility's policy titled, Fundamental of Infection Control Precautions, dated 2019, revealed: The following is a list of some situations that require hand hygiene . after contact with a resident's mucous membranes and body fluids or excretions; After handling soiled or used linens, dressings, bedpans . After removing gloves.

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.