STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676274	A. BUILDING _____ B. WING _____	**04/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REMARKABLE HEALTHCARE OF SEGUIN	**1339 EASTWOOD DR SEGUIN, TX 78155**

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 4 of 9 residents and 1 of 1 staff (Plant Manager) reviewed for hand hygiene, medication pass and wound care (Resident #1, #2, #3, #4), in that: 1. CNA A did not sanitize reusable medical equipment between residents during medication pass. 2. The Director of Plant operations did not perform hand hygiene properly after picking up an insect from the floor. 3. ADON B did not perform hand hygiene after touching a contaminated object before returning to wound care. 4. ADON B used clean gloves for wound care that were on top of a contaminated surface. 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: 1. Observation on 4/7/20 at 4 pm revealed LVN A took Resident # 1's blood pressure with a wrist blood pressure monitor, without sanitizing it. LVN A sanitized her hands, however, she placed the wrist blood pressure monitor on top of the medication cart without sanitizing it. Observation on 4/7/20 at 4:07 pm revealed CNA A took Resident # 1's blood pressure manually with an upper arm cuff. CNA A did not sanitize the blood pressure cuff prior to placing it on Resident # 1. Observation on 4/7/20 at 4:08 pm revealed CNA A did not sanitize the upper arm cuff and placed it back into the medication cart. Observation on 4/7/20 at 4:17 pm, revealed CNA A placed the upper arm cuff from the medication cart on Resident # 2's left arm and took his blood pressure, without sanitizing it before placing it on Resident # 2. CNA A walked out of Resident # 2's room, placed the blood pressure monitor back in the bottom left drawer of the med cart, without sanitizing. Observation on 4/7/20 at 4:25 pm revealed CNA A took Resident # 3's blood pressure with the wrist cuff from on top of the medication cart without sanitizing before using it. After taking Resident # 3's blood pressure, CNA A placed the wrist blood pressure monitor on top of the med cart but did not sanitize it. Observation on 4/7/20 at 4:40 pm revealed CNA A placed the wrist blood pressure monitor on Resident # 4's left wrist to take her blood pressure, without sanitizing it prior to placing on Resident # 4. CNA A placed the wrist cuff on the top of the med cart and did not sanitize it. During an interview on 4/7/20 at 5:24 pm, CNA A stated that last year state told her that she doesn't have to sanitize blood pressure monitors between residents. 2. Observation on 4/7/20 at 5:11 pm revealed the Director of Plant Operations, grabbed a paper towel to pick up a roach he had just stepped on in the laundry area, in front of the washing machines. He proceeded to wash his hands, however, he did not use a paper towel to turn off the water faucet, he used his hand. During an interview on 4/7/20 at 5:37 pm, the Director of Plant Operations stated the proper way to wash his hands was to turn off the faucet with his elbow or I guess you could use a paper towel, but the preferred method would be the elbow. He stated not using a paper towel to turn off the faucet was a bad habit. 3. Record review of Resident # 2's Face Sheet revealed he was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 2's Physician order [REDACTED]. During an interview on 4/7/20 at 1:24 pm, ADON B stated she should have washed her hands after touching anything, before donning her gloves to continue with wound care. 4. Record review of Resident # 2's Face Sheet revealed he was admitted on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident # 2's Physician order [REDACTED]. Observation on 4/7/20 at 1:33 pm revealed ADON B went outside of the Resident # 2's room, unlocked the supply cart, and took approximately 4-6 pairs of blue gloves out of the drawer in the supply cart, and set them on top of the cart, without wiping down the surface to ensure the top of the cart was sanitized. Observation on 4/7/20 at 1:35 pm revealed ADON B placed approximately 4-6 pairs of blue gloves on the resident's bedside table. ADON B washed her hands properly, however, she put on a pair of gloves from the resident's bedside table. She placed gauze, soaked in a rinse, on Resident # 2's wound. She washed her hands again and placed gloves on from the pile of gloves on the resident's bedside table. She opened a new pack of tubing and wound VAC. Observation on 4/7/20 at 2:00 pm of Resident # 2's bedside table revealed there were multiple drink ring stains. During an interview on 4/7/20 at 2:35 pm, ADON B acknowledged that she placed the clean gloves on a contaminated surface and used them for wound care. During an interview on 4/7/20 at 5:55 pm, the DON acknowledged that staff should have placed clean gloves used for wound care on a sanitized surface. Record review of a facility policy titled, Infection Control Guidelines for All Nursing Procedures revised December 2013, revealed hand hygiene should be performed after touching potentially contaminated objects or surfaces. Record review of a facility policy titled, Administering Medications staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) when these apply to the administration of medications. Record review of a facility in-service titled, Handwashing, conducted on 3/16/20, revealed paper towels should be used to dry hands, however, did not address how to properly turn off the faucet.

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.