STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675527	A. BUILDING _____ B. WING _____	09/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHISPERWOOD NURSING & REHABILITATION CENTER	**5502 W 4TH ST LUBBOCK, TX 79416**

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 -** Many	**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; in that: a)Staff failed to use appropriate infection control practices to prevent the spread of infections. Hand hygiene was not used between soiled activities and feeding Resident #3. Disposable gowns were not changed after personal care contact with Residents #1 and #4 in the dementia unit, b) Linens were not processed in a manner to prevent the spread of infections. There was no relative negative air pressure provided on the soiled side of the laundry, and c) PPE was not handled and stored in a sanitary manner. Bags of disposable gowns were placed on the corridor floor and was then stored in drawers with unbagged gowns. These problems could result in the spread of infections in the facility. The findings include: >Staff Infection Control Issues (Handwashing/Gown Changes): On 9/8/20 at 12:12 PM the Administrator stated that Resident #1 was on quarantine and resided on Hall C room [ROOM NUMBER] (dementia unit). Record review of the clinical record Resident #1 revealed that the resident was [AGE] years old and was newly admitted to the facility on [DATE]. Further review the clinical record revealed that the resident had [DIAGNOSES REDACTED]. On 9/8/20 at 11:23 AM an observation was made of dementia Hall C. CNA #1 was observed in Resident #4's room wearing a KN95 mask, face shield and disposable gown. She was fixing the residents hair and the resident's pants were on the floor. CNA #1 stated she had just changed Resident #4. The CNA was then asked about any changing guidelines for her disposable gown on the unit. She stated, I keep it on all shifts until I leave the unit. I think we should change them between residents (care), but I wasn't told to. This staff member did not change her gown after providing personal care to Resident #4 in her room. On 9/8/20 at 12:20 PM on Hall C residents were eating on disposable/plastic dishware. At that time 5 residents were eating independently in the unit dining room. It was also noted that Resident #1 was in her wheelchair and CNA #1 took her to room [ROOM NUMBER]. CNA #1 contacted the resident while she transferred the her to a low bed from her wheelchair then covered her with a blanket . The CNA was wearing a face shield, mask and gown. While the CNA was in the room she washed her hands and then left the room and picked up used resident meal trays in the dining room and put them on a dining room tray cart. She then went and sat down at a table and began feeding Resident #3. The CNA did not wash her hands or use hand hygiene between handling the soiled meal trays and feeding Resident #3. The CNA did not change her gown after providing care to Resident #1 and before feeding Resident #3. Record review of the Resident Roster dated 9/02/20 revealed that 6 of 8 residents on Hall C dementia unit had recovered from COVID-19 in the past. During an interview with the Administrator on 9/16/20 at 11:00 AM she stated that all residents on the Hall had tested negative for COVID-19 during their testing on 9/10/20 and 9/11/20. >Linen Infection Control Issues: On 9/8/20 and 9:00 AM an observation was made of the laundry. At that time there was no exhaust/relative negative air pressure on the soiled side as laundry was being processed in the washers and dryers. This was noted after checking the soiled side of the laundry and checking the outside vents. The only air movement on the soiled side was from air conditioner ducts which were providing positive air pressure. The curtain between the soiled and clean sides was not drawn. The curtain was cloth and had a mesh/fishnet top portion. On 9/8/20 at 10:20 AM an observation was made of the laundry with Laundry staff #1 processing soiled and clean laundry. There was no exhaust on or negative air pressure provided on the soil side of the laundry. As the soiled laundry was being processed there was only positive air pressure provided from the HVAC ducts on the clean and soiled laundry sides. When asked about any exhaust or negative air pressure for the soiled side, Laundry staff #1 observed the non-functioning louvered exhaust fan unit on the wall behind the washers. She stated, They (louvers) should lift up and down. She was then asked how long the exhaust fan had not been operational. She stated, I don't know how long. On 9/8/20 at 11:45 AM an interview was conducted with Maintenance Supervisor. He was asked if he checks the exhaust fan in the laundry. He stated, I think that's one of those things we checked. I check it when I check the dryers. He further stated, I don't think it ever worked. I don't know where the switch is for it. I've been here a year and a month. I haven't done anything with that (exhaust fan). The Maintenance Supervisor was asked if he had ever checked the exhaust fan on the soiled side in the laundry he stated, No. It never worked. Further observation of the laundry at this time revealed that there was a cloth curtains installed between the clean and soiled sides of the laundry. The curtain was fully open and had mesh cloth at the top. Other vents observed in the laundry revealed they provided no relative negative air pressure (water heater closet and center of laundry ceiling). On 9/8/20 at 1:50 PM the Maintenance Supervisor was asked if the facility had guidelines for the frequency of checking exhaust fans. He stated, It says monthly to check the exhaust fans and vents. Record review of the Maintenance Form Task Number 071 revealed the following, .Type: General Maintenance . Date Created: 8/12/20 at 9 AM. Comments: Exhaust fans: inspect exhaust fans for proper operation and clean if necessary. Steps: Check exhaust fans for proper operation. 1. Check all exhaust fans in . laundry areas . 2. Ensure that airflow is sufficient enough to hold a piece of paper to the event when operating . >PPE Handling/Storage: On 9/8/20 at 12:12 PM the Administrator stated that Resident #2 was on quarantine and resided in room [ROOM NUMBER] on Hall E. Record review of the clinical record Resident #2 revealed that the resident was [AGE] years old and was newly admitted to the facility on [DATE]. Further review the clinical record revealed that the resident had [DIAGNOSES REDACTED]. On 9/8/20 at 1:03 PM an observation was made of Staff Member #1 delivering packages of disposable gowns to the PPE storage cabinet in the corridor in front of room [ROOM NUMBER]. She placed the bags of gowns on the floor and then restocked the PPE cabinet drawers with the bags of gowns that were on the floor. There was an open bag of gowns in one of the drawers. On 9/8/20 at 1:05 PM an interview was conducted with Staff Member #1 and she was told of her error of placing the bags of disposable gowns on the floor. She stated, Oh that makes sense. I'm not a CNA. Policy: Record review the facility policy labeled Infection Control Plan: Overview, AD 03-1.0, Infection Control Policy And Procedure Manual 2018 revealed the following documentation, Infection Control. The facility will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection . Preventing Spread of Infection . 3. The facility will require staff to wash their hands after each direct resident contact for which handwashing is indicated by excepted professional practice. Linens. Personnel will handle, store, process and transport linens so as to prevent the spread of infection. Intent. The intent of this policy is to assure that the facility develops, implements, and maintains an infection prevention and control program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. The program will . Implement hand hygiene (handwashing) practices consistent with excepted standards of practice, to reduce the spread of infections and prevent cross-contamination; and properly store, handle, process, and transport minutes to minimize contamination. Record review the facility policy labeled Fundamentals Of Infection Control Precautions, Infection Control Policy And Procedure Manual 2018, A.D. 03-8.0, revealed the following documentation, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility. These measures make up the fundamentals of infection control precautions. 1. Hand hygiene. Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) that require hand hygiene . Before and after eating or handling food (handwashing with soap and water); before and after assisting a resident with meals . Consistent use by staff of proper hygienic practices and techniques is critical to preventing the spread of infections . 5. Gowns and protective apparel. 1. Gowns and protective apparel are worn to provide barrier protection and reduce the opportunity for transmission of microorganisms in the LTCF (Long Term Care Facility). Gowns are worn to prevent contamination of clothing and to protect the skin of personnel from blood and body fluids exposures. Gowns that are selected for use in the facility will be impermeable to liquids. 2. Gowns are also worn by personnel during the care of patients infected with epidemiologically important microorganisms to reduce their opportunity for transmission of pathogens from residents or items in their environment to other residents or environments; when gowns are worm for this purpose, they are removed before the personnel leave the residents environment . 7. Linen and Laundry. Although soiled linen may be contaminated with pathogenic microorganisms, the risk of disease transmission is negligible if it is handled, transported, and laundered in a manner that avoids transfer of microorganisms. Hygienic and common-sense storage and processing of clean and soiled linen is recommended .