STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676437	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCEL AT COLLEGE STATION	**1500 MEDICAL AVENUE COLLEGE STATION, TX 77845**

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.** Based on interview, observation 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 infection for equipment used on multiple residents in one (1) of two (2) dining rooms. A. LVN A failed to sanitize oxygen saturation pulse oximeter between residents in one (1) of two (2) dining rooms. This failure could place all residents at risk for the transmission of infectious diseases. Findings included: An observation on 8/12/2020 from 8:50-9:15 AM revealed LVN A was in the dining room obtaining O2 stats on seven (7) residents without sanitizing the oxygen saturation pulse oximeter device in between residents. An observation on 08/12/2020 at 9:10 AM revealed Resident # 6 licked her right index finger prior to placing finger in the saturation pulse oximeter device. An observation on 08/12/2020 at 9:13 AM revealed Resident #6 was complaining loss of appetite and couldn't taste anything. Resident #6 was also complaining she didn't feel good. An observation on 08/12/2020 at 9:18 AM revealed LVN A asked Resident #7 to put her finger in the device. LVN A didn't sanitize the saturation pulse oximeter device. LVN A had Resident #7's hand and was close to placing finger into the saturation pulse oximeter device when she was stopped by Surveyor. In an interview on 08/12/2020 at 9:22 AM LVN A stated, I didn't clean the O2 sat device (saturation pulse oximeter device) in between checking oxygen levels and pulse on residents in the dining room. I sanitize the O2 device prior to checking oxygen level and pulse on all residents. Furthermore, LVN A stated after all resident's oxygen level and pulse has been checked I sanitize the O2 device again. I do not sanitize the O2 device between residents. In an interview on 08/12/2020 at 10:05 AM The Director of Nurses stated, The oximeter device is required to be sanitized between use of each resident. All staff should sanitize the oximeter device prior to using the device on another resident. This is the facilities protocol. It was reported to me that Resident # 6 was complaining about loss of appetite and taste. We have ordered her a COVID test today (08/12/2020). In an interview on 08/12/2020 at 1:35 PM The Administrator stated, I expect all staff to use protocol when disinfecting/sanitizing any type of medical devices. This could cause cross contamination between residents. Resident #6 did have a COVID-19 test completed today (08/12/2020). I do consider the O2 sat device (saturation pulse oximeter device) as durable medical equipment. Record review of Facility Policy on Cleaning and Disinfection of Resident- Care Items and Equipment revised August 2010 stated, Reusable items are cleaned and disinfected or sterilized between residents. Durable medical equipment must be cleaned and disinfected before reuse by another resident.

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