STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675968	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STONE OAK CARE CENTER	505 MADISON OAK DR SAN ANTONIO, TX 78258

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 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observation and record review the facility failed to provide personal privacy during medical treatment for 1 (#1) of 3 Residents (Resident #1) in that: 1. RN A failed to pull Resident #1's privacy curtain all the way around the bed or close Resident #1's room door during personal wound care. This failure could affect residents who receive personal care in the facility and place residents at risk for a violation of their right to privacy and cause psychosocial harm. The findings were: Review of Resident #1's face sheet dated 9/4/20 revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's order summary report dated 9/4/20 revealed an order dated 8/25/20 to apply [MEDICATION NAME] gel mixed with collagen and bordered foam every 2 days for her left metatarsal head pressure injury. Review of Resident #1's Minimum Data Set (MDS), section M dated 6/17/20 revealed Resident #1 had an unhealed pressure injury. Review of Resident #1's care plan dated 6/10/20 revealed a care plan for her left metatarsal wound. An observation on 9/3/20 at 2:40 PM revealed RN A prepared supplies to perform wound care on Resident #1. RN A pulled the middle curtain on the right side of the Resident #1's bed, which ran from the head of the bed to the foot of the bed. RN A failed to pull the curtain on the left side of the bed to provide privacy on Resident #1's right side and the foot of the bed. Further observation revealed RN A did not close Resident #1's door during personal wound care. An observation on 9/3/20 at 2:49 PM revealed only the middle curtain pulled on the right side of the bed. Resident #1's bed was visible from the hallway outside Resident #1's room door. In an interview on 9/3/30 at 2:50 PM, the RN A confirmed she did not pull the curtain on the left side of Resident #1's bed, and did not close Resident #1's door during personal care. Further interview confirmed, with only the middle curtain pulled on the right side of the bed, Resident #1's bed was visible from the hallway outside of Resident #1's room door. In an interview on 9/4/20 at 1:45 PM, the DON confirmed staff were expected to provide resident privacy during personal care for dignity purposes. Further interview confirmed staff were expected to close window blinds, pull privacy curtains, and close the room door when personal care was provided. Review of the facility's Privacy and Confidentiality policy dated 2/2017 revealed Residents will be examined and treated in a manner that maintains privacy of their bodies . Team members will ensure that privacy curtains are pulled, doors are closed, or residents are otherwise removed from public view or covered or draped to prevent unnecessary exposure of body parts during the provision of personal care and services.
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 help prevent the development and transmission and disease and infection for 1 (#2) of 13 residents and 9 staff (CNA B, CNA C, LVN D, CNA E, Cook F, Cook G, Dietary aide, DM, and Activities Staff) observed for infection control in that: 1. CNA B failed to perform hand hygiene in accordance with facility policy while providing care to Resident #2. 2. The facility failed to clean/ sanitize the screening thermometer at the main entrance before and after use. 3. Cook F, Cook G, Dietary Aide, DM, and Activities Staff did not wear PPE (N95 Mask) correctly. These failures placed residents and staff at risk for contracting COVID-19 and other infections, decline in health status and death. The findings were: 1. Review of Resident #2's face sheet dated 9/4/20 revealed an admission date of [DATE] and [DIAGNOSES REDACTED]. An observation on 9/3/20 at 3:05 PM revealed CNA B apply gloves prior to care without washing her hands. CNA B touched the privacy curtains and bed remote with her clean gloves and then provided perineal care to Resident #2. CNA B removed her gloves and replaced them with a new pair without washing her hands. When she removed her gloves at which time a brown substance was observed on her gloves. CNA B removed her gloves and replaced them with a new pair without washing her hands. During an interview at 3:15 PM, CNA B confirmed she had not washing her hand before putting on her gloves or after removing them. In an interview on 9/4/20 at 1:50 PM the DON confirmed staff was expected to sanitize hands with alcohol- based hand gel or wash their hands with soap and water before and after glove use. Review of the facility's Hand washing/ hand hygiene policy dated 8/2015 revealed the staff were required to use alcohol- based hand rub containing at least 62% alcohol or alternatively, soap and water after removing gloves. Further review revealed the use of gloves did not replace hand washing/ and hygiene. 2. An observation on 9/3/20 at 2:00 PM revealed LVN D filled out the COVID-19 screening questionnaire at the front entrance of the facility. Further observation revealed LVN D picked up the thermometer without gloves, LVN D had not cleaned or sanitized the thermometer. LVN D scanned her own forehead, and placed the thermometer back on the table without cleaning or sanitizing the thermometer. Further observation revealed no disinfectant/ cleaner readily available to clean or sanitize the thermometer. An observation on 9/3/20 at 2:02 PM revealed CNA C filled out the COVID-19 screening questionnaire. Further observation revealed CNA C picked up the thermometer without gloves, CNA C had not cleaned or sanitized the thermometer. CNA C scanned her own forehead and placed the thermometer back on the table without cleaning or sanitizing the thermometer. Further observation revealed no disinfectant/ cleaner readily available to clean or sanitize the thermometer. An observation on 9/3/20 at 2:04 PM revealed CNA E filled out the COVID-19 screening questionnaire. Further observation revealed CNA E picked up the thermometer without gloves. CNA E had not cleaned or sanitized the thermometer. CNA E scanned her own forehead and placed the thermometer back on the table without cleaning or sanitizing the thermometer. Further observation revealed no disinfectant/ cleaner readily available to clean or sanitize the thermometer. In an interview on 9/3/20 at 2:05 PM, LVN D confirmed she had not cleaned or sanitized the thermometer she used to scan her forehead before or after use and stated there was nothing there to clean it. In an interview on 9/3/20 at 2:07 PM, CNA C confirmed she had not cleaned or sanitized the thermometer she used to scan her forehead before or after use. CNA C stated she should have sanitized it but she had received no specific training on sanitizing the thermometer. In an interview on 9/3/20 at 2:15 PM, the Administrator confirmed the same thermometer was used to monitor staff and essential visitor's temperatures at the main entrance of the facility. the Administrator confirmed there were no cleaning supplies readily available to staff to clean or sanitize the thermometer before and after use. Further interview confirmed staff were expected to sanitize the thermometer used for COVID-19 screening at the main entrance of the facility before and after use. In an interview on 9/3/20 at 2:19 PM the DON confirmed staff were expected to use disinfectant wipes to sanitize the thermometer between uses. In an interview on 9/3/20 at 2:22 PM, CNA E confirmed he had not cleaned or sanitized the thermometer he used to scan his forehead before or after use and stated he was in a rush. Review of the box instructions for the Brand of thermometer used for visitor and staff COVID-19 screening dated 2014 revealed Use an alcohol swab or cotton swab moistened with alcohol (70% [MEDICATION NAME]) to clean the thermometer casing and measuring probe. There was no guidance on how often to clean the thermometer. Review of the Centers for Disease Control and Prevention's Environmental Cleaning Procedures dated 4/21/20 revealed in healthcare facilities, shared equipment should be cleaned and disinfected before and after each use. 3. An observation on 9/4/20 at 10:46 AM in the kitchen during the lunch meal preparation revealed the Dietary Aide did not have on a mask/ face covering. Further observation revealed the Dietary Aide pulled a N95 mask from her pocket and put it on. In an interview on 9/4/20 at

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 -** Some	(continued... from page 1) 10:47 AM the Dietary Aide confirmed she was not wearing a mask or eye protection because she had just come from the restroom. Further interview revealed she cut the straps on the N95 mask because it was too tight. An observation on 9/4/20 at 10:48 in the facility's kitchen during the lunch meal preparation revealed Cook G not wearing a mask/ face covering. Further observation revealed Cook G place a N95 mask on her face with straps on the N95 Particulate Respirator modified to fit behind her ears. In an interview on 9/4/20 at 10:49 AM Cook G confirmed she was not wearing a mask because she needed a break from the mask. Further interview revealed she cut the straps on the N95 mask because it was too tight. An observation on 9/4/20 at 10:51 in the facility's kitchen during the lunch meal preparation revealed Cook F, wore a N95 mask on her face with straps modified to fit behind Cook F's ears. In an interview on 9/4/20 at 10:52 AM, Cook F confirmed she cut the straps to make N95 mask fit behind her ears. Further interview revealed Cook F was aware she was not supposed to change the straps on the N95 mask. An observation on 9/4/20 at 10:54 AM in the facility's kitchen revealed the DM wore a Brand N95 mask with the straps behind her ears. In an interview on 9/4/20 at 10: 54 AM, the DM confirmed she had changed the straps on the N95 mask to fit behind her ears because the mask was too tight. Further interview revealed the kitchen staff were expected to have on a mask while on duty and were trained to not change the masks. An observation on 9/4/20 at 10:56 AM in the main dining room revealed one of the Activities Staff wore a N95 mask with the straps behind her ears. In an interview on 9/4/20 at 11:00 AM the Activities Staff confirmed she had changed the connection of each strap on the Brand N95 Particulate Respirator mask to fit around her ears. In an interview on 9/4/20 at 2:00 PM the Administrator confirmed all staff were required to wear a mask while on duty. Further interview confirmed staff were expected to wear masks/ respirators according to manufacturer's guidelines. Review of N95 mask container instructions revealed 1. Unfold the mask and hold it with both hands, with the metallic strip facing up .2. Place elastic bands around the neck and head respectively. Put the mask against your face covering both nose and mouth .3. Adjust the metallic strip cover bridge of the nose using two fingers to press down until achieving a close fit .4. Perform a fit check according to instructions .Fit Check .1. Place both hands over mask .2. Take a deep breath and hold your breath for a few seconds, making sure the mask collapses inward as you inhale .3. Then exhale and hold your breath for a few seconds, making sure the mask bulges outward as you exhale .4. If air leaks, reposition the mask, tighten the metallic strip and reposition the elastic bands for a better fit. Follow steps 1-3 again until a tight seal has been achieved .5. Masks that have passed the fit check are now safe to use. Review of the facility's N95 mask instruction cautions and limitations documented Never substitute, modify, add, or omit parts. Further review revealed Improper use may lead to illness and even death.