STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676136	A. BUILDING _____ B. WING _____	06/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUEBNER CREEK HEALTH & REHABILITATION CENTER	8306 HUEBNER RD SAN ANTONIO, TX 78240

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 establish and 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 for 2 of 5 residents (Residents #1 and #2), 6 of 6 staff (LVN A, LVN B, CNA C, Social Worker D and 2 unidentified staff) and 1 of 8 resident halls (500 hall) reviewed for infection control. 1. The facility failed to ensure Social Worker D and 2 unidentified female staff were doffing PPE in designated areas of the facility before leaving the building. 2. Staff (LVN A, LVN B and CNA C) did not adhere to policies and procedures for droplet transmission-based precautions for a resident on observational quarantine on the 500 hall. 3. The facility failed to ensure the skilled nursing notes for Residents #1 and #2, who were on observational quarantine, documented they were on contact and droplet transmission-based precautions. These deficient practices could affect all residents and place the residents at risk for mental anguish, prolonged isolation time, coronavirus infections (COVID-19) and possible death. The findings included: 1. During an interview on 6/15/20 at 12:03 p.m., the Administrator reported because of the facility finding out they had a resident test positive for COVID-19, they implemented that all staff must be wearing a N-95 mask and gown while in the building. The Administrator and DON also reported residents were to wear surgical masks and gowns if they are to be outside their rooms. The Administrator and DON reported they have not had any residents exhibit signs and symptoms of COVID-19, but they do have residents on observational quarantine, who require contact and droplet transmission-based precautions. An observation on 6/15/20 at 12:44 p.m., revealed two unidentified female staff go out the facility's front door with a gown and N-95 mask on. An observation with the Administrator on 6/15/20 at 12:53 p.m., revealed the same two unidentified female staff members that left the building with the gown and N-95 masks on coming back into the building with the same PPE. The Administrator confirmed the staff coming in with PPE should have taken the PPE off before leaving the building. The Administrator revealed she would talk with her staff. During an interview on 6/15/20 at 4:22 p.m., the Director of Environmental Services confirmed the facility had designated room [ROOM NUMBER] and the beauty shop as place for staff to don and doff their PPE. An observation with the Administrator on 6/15/20 at 5:40 p.m. revealed the facility's Social Worker D leaving the facility with a gown and N-95 mask on. The Administrator confirmed the Social Worker should have taken the gown and mask off before leaving the facility. The Administrator confirmed the facility had designated the beauty shop and room [ROOM NUMBER] as places for staff to take off their PPE before leaving the building. 2. An observation on 6/15/20 at 1:16 p.m., revealed LVN B coming out of resident room [ROOM NUMBER], which was an observational quarantine room. LVN B exited the room with a gown, face shield and N-95 mask donned. LVN B sanitized his hands with the sanitizer from the pump outside the door but did not disinfect his face shield or take it off before exiting the room. LVN B then proceeded down the hall with the face shield on. During an interview on 6/15/20 at 1:16 p.m., LVN B confirmed resident room [ROOM NUMBER] was an observational quarantine room. LVN B confirmed he did not take off or disinfect the face shield after leaving resident room [ROOM NUMBER]. LVN B reported they usually keep the face shields in a brown bag in the ADON or DON's offices. An observation from the DON's office on 6/15/20 at 1:20 p.m., revealed staff LVN A and LVN B wearing face shields right side up (the face shield's clear plastic part was pointed up towards the ceiling) while at Nurse Station #2. During an interview on 6/15/20 at 1:24 p.m., DON confirmed the staff should not be wearing the face shields right side up. The DON reported the staff should disinfect the face shields between residents and place them in a brown bag. The DON also reported some of the staff like to keep the face shields on out of precaution. The DON confirmed LVNs A and B worked with residents who are and are not on observational quarantine. During an observation and interview on 6/15/20 at 1:40 p.m. LVN A was seen walking to her medication cart by Nursing Station #2 with a face shield donned. LVN A reported she kept her face shield on in the resident rooms who were and were not on observational quarantine. LVN A reported she disinfects the face shield once she leaves the resident's room with the K-Quat. LVN A revealed she kept the K-Quat in her medication cart. During an interview on 6/15/20 at 1:42 pm the DON reported the facility had enough face shields. The DON revealed they were not using one face shield per resident on observational quarantine, but they could use the same face shield with all of the residents on observational quarantine as long as they disinfected it and placed it in the brown bag between use. The DON revealed the staff do not have to change their gowns unless they were providing care for a resident on quarantine/isolation where there was the potential for splatter or spraying of fluids. During an observation with the DON on 6/15/20 at 1:30 p.m., revealed CNA C in resident room [ROOM NUMBER] with a yellow gown, n-95 and gloves donned, but no face shield. CNA C was tying plastic bags with trash on the bins by the door. The DON confirmed CNA C, should have had a face shield on while she was in the resident's room because they were on observational quarantine. The DON asked CNA C what type of care she provided for the resident and she stated she provided peri care for the resident. The DON asked where her face shield was, and CNA C reported that she forgot it and that she would need to get another one. The Resident in room was coughing which the DON confirmed. The DON then asked CNA C if she took it off and put in the trash and she said yes. The DON reported that if she took it off and put it in the trash she should have another one available to put on while she was in the resident's room and that she needed another while in the room. The DON confirmed the resident was on droplet and contact precautions. The DON said they do not have to have a different face shield for each resident, but that it must be disinfected after coming out of the room. Record review of the K-Quat Cleaner Disinfectant label, undated, revealed for spray applications, spray 6-8 inches from surface. Do not breathe spray. Treated surfaces must remain wet for 10 minutes. Wipe dry or allow to air dry. Record review of the facility's in-service titled PPE Use for Contact/Droplet Precautions for resident who do not have Confirmed COVID-19 The following measures are approved by the CDC during Crisis Optimization of PPE, dated 5/22/20, read if any of the following are to occur, all PPE is required: -during the high contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as: dressing, bathing/showering, transferring, providing hygiene, changing linen, changing briefs or assisting with toileting, device care or use, wound care . PPE required: KN-95 mask, N-95 if no KN-95's are available, eye protection, gown and gloves. (.) Before leaving the room: if gown was used, discard it; if gloves were used, discard them; if eye protection was used, remove and disinfect; continue to wear the same N95 or KN95, unless an aerosolization procedure was performed, or it is soiled or broken. 3. Observation on 6/15/20 at 1:04 p.m. revealed Resident #1's and #2's rooms were labeled with information on contact and droplet precautions and that they had an isolation carts outside each room. Record review of Resident #1's face sheet, dated 6/17/20, revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's Order Summary Report, dated 6/17/20, revealed an order for [REDACTED].#1's June MAR, dated 6/17/20, documented the resident's order for Contact/Droplet Precautions per facility protocol every shift for 14 Days was administered from 6/14/20-6/17/20. Record review of Resident #1's Skilled Nurses Notes, dated 6/14/20, 6/16/20 and 6/17/20, indicated no for the question Is the resident on any transmission-based precautions? Record review of Resident #2's face sheet, dated 6/17/20, revealed the resident admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #2's Order Summary Report, dated 6/17/20, revealed an order for

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) [REDACTED].#2's June MAR, dated 6/17/20, documented the resident's order for Contact/Droplet Precautions per facility protocol every shift for 14 Days was administered from 6/03/20-6/17/20. Record review of Resident #2's Skilled Nurses Notes, dated 6/14/20, 6/16/20 and 6/17/20, indicated no for the question Is the resident on any transmission-based precautions? During an interview on 6/19/20 at 11:15 a.m., the Administrator confirmed Resident #1's and #2's Skilled Nursing Notes were not coded for use of transmission-based precautions. The Administrator confirmed Resident #1 and #2 were on contact and droplet precautions during the days the nurses' notes were completed and they should have been coded as on transmission-based precautions.