STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676353	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CORONADO AT STONE OAK	**19638 STONE OAK PARKWAY 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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 control program designed to prevent the development and transmission of infection to include hand hygiene for 3 of 4 residents (Resident #1, #2, and #3) reviewed for infection control, in that: 1. LVN A did not sanitize or wash her hands after removing her gloves and before exiting Resident #1's room. 2. a. CNA B did not sanitize or wash her hands after removing her gown and gloves and taking out trash in Resident #2's room. b. CNA B did not sanitize or wash her hands after removing her gown and gloves and taking out trash in Resident #3's room. These deficient practices could place residents in the facility at risk for spreading infection and cross contamination. The findings were: 1. Record review of Resident #1's face sheet, dated 8/11/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Record review of Resident #1's August 2020 Physician order [REDACTED]. Observation on 8/11/2020 at 8:49 AM revealed LVN A entered Resident #1's room in 200-hallway where the facility considered as cold zone since the Resident #1 was not COVID-19 positive. With gloves on, LVN A checked Resident #1's blood pressure, temperature, oxygen, and administered oral medication to Resident #1. Observation on 8/11/2020 at 8:51 AM revealed LVN A removed her gloves after taking Resident #1's vital signs and administering medication. LVN A did not sanitize or wash her hands before or after exiting Resident #1's room. Interview on 8/11/2020 at 8:54 AM with LVN A, confirmed she did not sanitize or wash her hands after removing her gloves and before exiting Resident #1's room. LVN A confirmed she was talking with Resident #1, and forgot to sanitize or wash her hand. Interview on 8/11/2020 at 3:15 PM with the DON, confirmed LVN A should have sanitized or washed her hands after removing her gloves and before proceeding to the next task or the next patient. 2. a. Record review of Resident #2's face sheet, dated 8/11/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. b. Record review of Resident #3's face sheet, dated 8/11/2020, revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. Observation on 8/11/2020 at 9:29 AM revealed CNA B placed a big trash bag which had gowns, gloves, Styrofoam cups, and Styrofoam food containers at Resident #2's the door entrance. CNA B put on gown and gloves before entering Resident #2's room. CNA B took a Styrofoam food container on Resident #2's bedside table to put inside Resident #2's trashcan which was lined with a small clear trash bag. CNA B took off her gown and gloves, and she put the discard gown and gloves in Resident #2's trash can. CNA B took out the small clear trash bag from Resident #2's trash can and put into the big trash bag at Resident #2's door entrance. CNA B did not sanitize or wash her hands after taking off her gown and gloves and after taking out the trash Resident #2's room. CNA B proceed to Resident #3's entrance with her big trash bag. Further observation on 8/11/2020 at 9:32 AM revealed CNA B set the big trash bag down in front of Resident #3's door entrance. Without sanitizing or washing her hands, CNA B put on a new gown and gloves before entering Resident #3's room. CNA B took the Styrofoam food container on Resident #3's bedside table put into a small clear trash bag inside Resident #3's room. CNA B took off her gown and gloves and put into the small clear trash bag. CNA B put the small clear trash bag into the big trash bag at Resident #3 door entrance. CNA B did not sanitize or wash her hands after removing her gown and gloves and after removing the trash from Resident #3's room. CNA B then proceed to the next resident's entrance with her big trash bag. Interview on 8/11/2020 at 9:50 AM with CNA B confirmed she did not sanitize or wash her hand after removing her gown and gloves and after removing trash from Resident #2's room. Interview on 8/11/2020 at 9:52 AM with CNA B confirmed she did not sanitize or wash her hand after removing her gown and gloves and after removing trash from resident #3's room because she forgot. Interview on 8/11/2020 at 3:17 PM with the DON confirmed CNA B should have sanitized or washed her hands in between residents. Record review of the facility's nursing policy and procedure titled Handwashing, dated 08/2012, revealed handwashing is the single most important means of preventing the spread of infection. The principle of hand washing is that of using friction to mechanically remove micro-organism. After patient contact: wash hands with soap and running water . may use hand sanitizing gel in place of soap and water. Record review of Hand Hygiene in Healthcare Settings by CDC retrieved from https://www.cdc.gov/handhygiene/providers/index.html on 8/12/2020 revealed Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: use an alcohol base hand sanitizer after touching a patient or the patient's immediate environment . immediately after glove removal. .

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.