STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455423	A. BUILDING _____ B. WING _____	**04/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SCC AT VALLEY GRANDE	**901 WILDROSE LN BROWNSVILLE, TX 78520**

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 maintain an infection and prevention control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection and that included, at a minimum, a system for preventing and controlling infections, for two Residents (R#1 and R#2) of three residents reviewed infection control practices, in that: 1) RN A did not properly disinfect work area surfaces when preparing wound treatment supplies for wound care for R#1. 2) The facility did not perform screening for signs and symptoms of COVID-19 for R#2's FM B who was a visitor that resided in R#2's room since the facility went on lockdown in March 2020. These failures could place residents that were dependent upon care at risk for infections and cross-contamination. The findings were: 1) Record review of R#1's Admission Record, dated 0[DATE]3/20, revealed R#1 was a [AGE] year-old male who was admitted to facility on 12/26/19 with [DIAGNOSES REDACTED]. Record review of R#1's Physician Orders, dated 0[DATE]3/20, revealed the following orders for wound treatment for [REDACTED].#1's sacrum: -[MEDICATION NAME] Ointment 0.1 %, cleanse w/Dakin's 0.25% sol, pat dry w/gauze, apply [MED] oint (nickel thick amt), then [MEDICATION NAME] 0.1% oint, cover w/[MEDICATION NAME] Alginate and gauze, then secure w/Dry protective dressing QD and PRN until resolved, start date, 01/14/20. -[MED] Ointment 250 Unit/GM ([MEDICATION NAME]). Apply to Sacrum topically as needed for Stage 4 Pressure Ulcer Injury. Cleanse w/Dakin's 0.25% Sol, pat dry w/gauze, Apply [MED] oint (nickel thick amt), then [MEDICATION NAME] 0.1% oint, cover with [MEDICATION NAME] Alginate and gauze, then secure w/Dry protective dressing QD and PRN until resolved, start date, 01/14/20. Observation on 0[DATE]0/20 at 1:23 p.m. revealed RN A was in the hallway in front of R#'s room. RN A sanitized her hands and donned gloves. RN A prepared and placed wound treatment supplies on the top surface of her medication cart, next to her laptop, without disinfecting or placing a barrier for the wound treatment supplies. RN A then walked into R#1's room and placed all the wound treatment supplies on an overbed table without a barrier, and without disinfecting the overbed table. RN A removed her gloves, sanitized her hands, and donned new gloves. RN A and CNA B proceeded to remove R#1's clothing and pillows to prepare R#1 for wound treatment. In an interview at the time of the observation, RN A said she had not asked CNA B if she had disinfected the overbed table. CNA B said she had not disinfected the overbed table. RN A said she would throw away the wound treatment supplies and start the new preparation of wound treatment supplies again. CNA B was observed disinfecting the overbed table and RN A prepared the wound treatment supplies and placing them on top of the medication cart. In an interview on 0[DATE]0/20 at 3:10 p.m., RN A said she had not disinfected her med cart or placed a barrier on top of her med cart before she placed the wound treatment supplies for R#1's wound treatment on it. RN A said she had just been assigned the position of Wound Treatment Nurse and was nervous. In an interview on 0[DATE]3/20 at 11:28 a.m., the ADON/LVN C said before placing any wound treatment supplies on any surface, the surface must be disinfected, and a barrier placed between the surface and supplies, such as wax paper, napkins, etc . Record review of the facility policy titled, Skin -Wound Care, dated 02/20/20 revealed: -The purpose of this policy is to provide a guideline for proper wound care. -Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field. Arrange supplies so they can be easily reached. 2) Record review of R#2's Admission Record, dated 0[DATE]3/20, revealed R#2 was a [AGE] year-old male who was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Record review of R#2's care plan, initiated [DATE], revealed, Client is at risk for exposure to infectious disease: COVID-19 [MEDICAL CONDITION], Cerebral Infarction, Weakness. Interventions initiated on [DATE] included: -Educate staff, client, family and visitors of COVID-19 s/sx as well as precautions. Follow facility protocol for COVID-1 screening and precautions. -Observe for s/sx of COVID; document and promptly report s/sx: Fever, New/Worsening Cough, Sore Throat, SOB. Record review of nurse's notes for R#2, dated 03/27/20, indicated: in bed tx to sacral area done and creams applied as ordered, (FM 'D') continues to be present during care and bath and stops cnas to suction or she wants to shampoo residents head but she stops often to suction him orally at times tiring the patient so much that he goes into a daze, she continues to do this even after speaking to her about importance of doing in a timely manner. Record review of nurse's notes for R#2, dated 04/07/20, indicated: (FM 'D') at bedside, resident on vent (ventilator - machine that provides mechanical ventilation by moving breathable air into and out of the lungs) with no distress at this time, (FM 'D') continues to suction him orally and [MEDICAL CONDITION](artificial opening into the windpipe) during care per staff. Observation on 0[DATE]0/20 at 1:44 p.m. revealed R32 was in bed [MEDICAL CONDITION] [MED]gen. R#2's FM D (non-resident) was in R#2's room, in the bed closest to the room door. In an interview on 0[DATE]0/20 at 1:44 p.m., FM D said she had lived in R#2's room since August 2019, when R#2 was initially admitted . In an interview on 0[DATE]3/20 at 9:30 a.m., the Administrator said R#2 was admitted from the hospital, under private pay. The Administrator said R#2's FM D had been staying with R#2 in his room since R#2 was admitted to facility. The Administrator said FM D was allowed to stay and live with R#2 to help R#2 with his psychological status, anxiety, and depression. The Administrator said FM D had been going in and out of the facility before the facility lockdown had begun around March 2020. After the orders to stay in shelter, FM D had not left the facility. The Administrator said, as far as she knew, FM D had not been screened for s/sx of COVID-19 since the screenings had begun. The Administrator said FM D would be included in the screening process beginning today. In an interview on 0[DATE]3/20 at 11:02 a.m., ADON/LVN E said she and ADON/LVN C were the staff assigned to coordinate and implement the Infection Prevention and Infection Control Program. ADON/LVN E said the former DON had left approximately two weeks before. ADON/LVN E said R#2's FM D had been living with the resident in his room. ADON/LVN E said R#2's FM D had not left the facility since the lockdown, but had not been screened for COVID-19 signs and symptoms. ADON/LVN E said the Administrator told her to start screening FM D as of today. ADON/LVN E said she understood visitors, including family members, were to leave the facility, but the Administrator had called Corporate office and FM D was allowed to stay. In an interview on 0[DATE]3/20 at 11:28 a.m., ADON/LVN C said FM D had not been screened for COVID-19 signs and symptoms since the lockdown had been implemented as part of the IPIC program. ADON/LVN C said FM D had not been allowed to leave R#2's room. Record review of facility's undated policy titled, Coronavirus Emergency Pandemic Policy revealed: The center's [MEDICAL CONDITION] infection control program includes early identification, isolation and transfer of persons with active Coronavirus. Screening and surveillance of residents and employees for signs and symptoms of fever, cough and shortness of breath, mild to moderate upper respiratory tract illnesses, like the common cold. Symptoms may appear anywhere from 2 to 14 days after exposure. Screening forms will be completed daily on all residents (COVD-19 Screen); Before the start of workday for each employee (Employee Screen); prior to entering facility for any visitor/vendor (Visitor/Vendor Screen). Visitor and Vendor screening will continue with approved form: Visitors/Vendors (visiting per approval) must be able to demonstrate the hand hygiene (use the hand washing competency.)

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.