STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675049	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coronado Healthcare Center	1504 W Kentucky Ave Pampa, TX 79065

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. 47159 Based on observations, interviews, and record reviews 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 3 of 8 employees (CNA A, LVN B and RNRS C) reviewed for infection control. The facility failed to ensure CNA A, LVN B, and RNRS C practiced proper hand hygiene while serving and assisting residents during the lunch meal on 2/5/25. This failure could place residents at risk of the spread of communicable diseases and infections and a diminished quality of life. Findings included: An observation of the lunch meal on 02/05/2025 between 12:00PM and 12:30PM revealed CNA A, LVN B and RNRS C assisted in the dining room. CNA A was observed using ABHR while standing in the service line. CNA A placed her hands in her pockets immediately after the use of ABHR and they remained in her pockets until she received a resident tray from the kitchen. CNA A left the service line with the resident's tray. While on her way to deliver the tray, CNA A dropped a single-serving butter pat on the floor. CNA A was then observed to pick up the butter pat from the floor and place it back on the resident's tray. She delivered the tray to the resident and returned to the service line, without sanitizing her hands. CNA A was observed several times during the luncheon service, using ABHR and then placing her hands in her pockets or on her hips while waiting. LVN B was observed using ABHR upon entry to the dining room, but then placed her hands on her hips, touching her clothing. LVN B's hands remained on her hips while she was waiting for a tray from the service line. LVN B received a tray from the kitchen and served it to a resident without re-sanitizing her hands. RNRS C was observed leaning against the ice machine, with her right hand resting on top of the machine. The RNRS then received a tray from the kitchen and proceeded to help a resident who needed set-up and minimal feeding assistance with his meal. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with RNRS C on 02/05/2025 at 1:47PM reflected she was aware of the lapse in hand hygiene and would take steps to do things better next time. RNRS C stated the negative outcome of not sanitizing her hands between resident trays was the possibility of cross-contamination or spreading of germs which might be infectious. An interview with LVN B on 02/05/2025 at 1:51PM reflected she denied the lapse in hand-hygiene. LVN B stated the negative outcome of not sanitizing her hands between resident trays would be the potential transmission of infections. Record review of the facility's employee roster reflected LVN B was the only employee with her first and last name, working at the facility, which indicated LVN B was the only LVN in the dining room during the lunch meal. An interview with CNA A on 02/05/2025 at 2:00PM revealed she realized the lapse in hand hygiene as soon as she received the resident's tray from the kitchen. CNA A stated the negative outcome of not practicing proper hand hygiene would be the spread of germs or sicknesses. An interview with the ADON on 02/05/2025 at 3:15PM revealed LVN B did not take responsibility for her actions at times, did not like to be questioned about her abilities. The ADON stated LVN B had been coached regarding customer service and employee relations. The ADON stated an in-service was going to be done on hand hygiene, starting immediately and would be passed on to the night supervisor for training of the night staff. Record review of facility policy and procedures for hand hygiene dated 01/20/2023 revealed the following: Policy Interpretation and Implementation: 1. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 3. Wash hands with soap; and water, when hands are visibly soiled and after contact with a resident with an infectious diagnosis. 4. Use an alcohol-based hand rub containing at least 60%-95% ethanol alcohol or isopropyl alcohol. Procedure: Using Alcohol-Based Hand Rubs: 1. Apply generous amount of product to palm of hand and rub hands together. 2. Cover all surfaces of hands and fingers until hands are dry The facility did not have a policy regarding hand hygiene while serving resident meals.