STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675034	A. BUILDING _____ B. WING _____	**06/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PENNSYLVANIA NURSING AND REHABILITATION CENTER	**901 PENNSYLVANIA AVE FORT WORTH, TX 76104**

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 prevention and control program that included a system for preventing and controlling infections and communicable diseases for four (LVN W, Medication Aide AA, Housekeeper Y, and CNA D) of four staff reviewed for infection control. The facility failed to ensure staff were [MEDICATION NAME] appropriate infection control procedures during resident care, medication administration, cleaning, and preparing meals. This failure could place residents at risk of cross contamination that could result in infections or illness. Findings included: An observation on 04/29/20 at 3:05 PM revealed LVN W was at the medication cart wearing a mask and gloves while preparing to obtain a resident's blood sugar. LVN W sanitized the glucometer before entering the resident's room. LVN W entered the room and obtained the resident's blood sugar. LVN W left the resident's room, placed the glucometer on the medication cart, degloved, and began to obtain medication from the cart without performing hand hygiene. An observation on 04/30/20 at 3:30 PM revealed LVN W was observed taking Resident #1's temperature, O2 saturation, and blood pressure. LVN W changed his gloves but did not perform hand hygiene after taking Resident #1's vital signs. He did not sanitize the equipment before beginning to take Resident #2's vital signs. LVN W documented vitals for Resident #2. LVN W removed his gloves, donned new gloves, but did not perform any hand hygiene. He did not clean the equipment before going to the next resident. He obtained Resident #3's vital signs, took his gloves off, left the room to get another pair of gloves from linen cart in the hallway, returned to the resident's room, and donned the new gloves without performing hand hygiene. LVN W did not clean or sanitize the equipment before utilizing to obtain Resident #4's vital signs. An interview on 04/30/20 at 4:18 PM with LVN W revealed he did not sanitize the equipment between each resident but should have to prevent cross contamination. He did not sanitize his hands between each resident before donning new gloves. An observation on 04/30/20 at 5:20 PM with Medication Aide AA revealed a medication cup was tipped over and the medication had spilled over onto the top of the medication cart. Medication Aide AA picked up the pills with her bare hands and placed them back into the medication cup. An observation on 04/30/20 at 5:39 PM revealed Medication Aide AA donned two pairs of gloves, a gown, shoe covers and a shield to distribute medications to a resident identified on isolation. An observation on 04/30/20 at 5:50 PM revealed Medication Aide AA stepped in the doorway of resident's room to administer medications. She administered medications to one resident then returned to the medication cart. MA AA used hand sanitizer on her gloved hands before administering medication to the roommate. She then removed the two pairs of gloves. An interview on 05/01/20 at 3:00 PM with Medication Aide AA explained yesterday (04/30/20) she admitted to placing hand sanitizer on the gloves but did not explain why. There were some pills from a medicine cup that spilled onto the medication cart and she took her ungloved hands and placed the medication back into the medication cup. She stated should have performed hand hygiene between each resident and glove changes and her not washing/sanitizing hands was cross contamination. An observation on 05/01/20 at 1:24 PM revealed Housekeeper Y did not perform hand hygiene between glove changes after cleaning a resident's room. She touched the door knob from one resident room to the next with the same soiled gloved hands. An observation on 05/01/20 at 1:40 PM revealed Housekeeper Y cleaned the room of a resident. She exited the room, pulled the door closed by the handle while wearing the same gloves worn while cleaning the room, and then she removed her gloves. An interview on 05/01/20 at 1:43 PM with Housekeeper Y, she revealed she should wash/sanitize her hands after each glove change. An interview on 05/01/20 at 1:50 PM with the DON revealed donning two pairs of gloves was not allowed. She stated hand hygiene should be performed between each glove change. An observation on 05/12/20 at 2:20 PM revealed CNA D went to Resident #6's room to perform initial round checks. CNA D gloved one hand and went into the room to check on Resident #6. There was blood observed around the resident's mouth and nose area due to being shaved. CNA D went to the linen cart to get a wipe for the resident's mouth. She pulled more wipes than needed so with her ungloved hand pushed the unneeded wipes back into the package. CNA D returned to Resident #6's room with wipe and began to wipe Resident #6's mouth. She noticed blood on Resident #6's shirt and wanted to change Resident #6's shirt. CNA D went to the closet to get a shirt with the same gloved hands. CNA D touched the roommate's clothes before finding Resident #6's clothes. CNA D took bloody sheets off the bed, balled the sheets, and placed soiled sheet on the nightstand. CNA D left the room with same gloved hands to get a pillowcase and a bag for the linen. CNA D returned to the room and bagged the linen off the nightstand. CNA D opened a lid off a cup to assist Resident #6 with a drink with the same gloved hands. Review of the facility's undated policy on handwashing reflected: Policy: Hand washing Purpose: Hand washing will be regarded by this facility as the single most important means of preventing the spread of infections. Procedure: 1. All personnel will follow the facility's established handwashing procedures to prevent the spread of infection and disease to other personnel, residents and visitors. 2. Hands should be washed ten (10) to fifteen (15) seconds under the following conditions: a. When coming on duty b. Whenever hands are obviously soiled c. Before performing invasive procedures d. Before preparing or handling medications e. Before handling clean or soiled dressing, gauze pads f. After handline used dressing, contaminated equipment g. After contact with blood, body fluids, excretions, secretions, mucous membranes or nonintact skin. h. After handling items potentially contaminated with blood, body fluids, excretions, or secretions. i. After using the toilet, blowing or wiping of nose, smoking, or combing the hair j. After removing gloves k. Before and after eating . Review of the facility undated policy on gloves for Infection Control reflected: Objectives 1. To prevent the spread of infection 2. To protect wounds from contamination 3. To protect hands from potentially infectious material Miscellaneous 1. When gloves are indicated, use disposable single-use gloves. 2. Discard used gloves into the waste receptacle inside the examination or treatment room. 3. Use sterile gloves for invasive procedures to prevent contamination of the patient, and to decrease the risk of infection when changing dressings. 4. Wash hands after removing gloves . Review of the facility's undated policy on Cleaning and Disinfecting Equipment for Housekeeping and Maintenance reflected: Policy: Cleaning and Disinfecting Equipment Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. 1. The following categories are used to distinguish the levels of sterilization/disinfection necessary for items used in resident care, a. Critical items consist of items that carry a high risk of infection if contaminated with any microorganism. Objects that enter sterile tissue like a urinary catheter or intravenous catheter are considered critical items and must be sterile. b. Semi-critical items consist of items that may come in contact with mucous membranes or non-intact skin. Such devices should be free from all microorganisms, although small numbers of bacterial spores are permissible. c. Non-critical items are those that come in contact with intact skin but not mucous membranes i. Bedpans, blood pressure cuffs, crutches and computers ii. Most non-critical reusable items can be decontaminated where they are used d. Reusable items are cleaned and disinfected or sterilized between residents (stethoscopes, durable medical equipment

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.