STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675495	A. BUILDING _____ B. WING _____	**09/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAUREL COURT	**3830 MUSTANG ROAD ALVIN, TX 77511**

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 an infection prevention and control program that included hand hygiene procedures to be followed by staff involved in direct resident contact for two of two residents (Resident #1) and Resident #2), and two of CNA's (CNA A and CNA B) reviewed for infection control. - CNA A failed to provide appropriate incontinent care -CNA A and CNA B failed to perform appropriate hand washing techniques during incontinent care These failures could affect all residents for incontinent cares at risk for infections. Findings include: Resident #1 Record review of Resident #1's face sheet on 9/2/20 at 2:30pm revealed he was [AGE] years old and admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's significant change MDS assessment on 9/2/20 at 3:30 pm, dated 3/26/2020 revealed he had a BIMS score of 9 of 15 which indicated that he was moderately cognitively impaired. He required extensive assistance from two people for bed mobility. He required extensive assistance from at least one staff member for transfers, dressing, eating, toilet use and personal hygeine. He was also coded as being always incontinent of bowel and bladder. Record review of Resident #1's care plan on 9/2/20 at 3:35pm, and dated as Effective: 1/6/2020-Present revealed the facility had approaches in place to address Resident #1's incontinence and prevent skin breakdown. Some of the interventions read as follows: Check for incontinence; change if wet/soiled. Clean skin with mild soap and water. Apply moisture barrier. STATUS: Active (Current). He also had the following entry listed under the heading Problems. Urinary Continence: Resident #1 is always incontinent. STATUS: Active (Current). Resident #2 Record review of Resident #2's face sheet on 9/2/20 at 2:40 pm, revealed he was an [AGE] year old male who admitted to the facility on [DATE]. His daignoses included dehydration, dementia, type II diabtes mellitus, [MEDICAL CONDITION], hypertension, [MEDICAL CONDITION], anorexia, pressure ulcer of the right heel, [MEDICAL CONDITION], and functional intestinal disorder. Record review of Resident #2's annual MDS assessment on 9/2/2020 at 3:40 pm and dated 7/17/2020 revealed he had a BIMS score of 2 of 15 indicating he was severely cognitively impaired. He required extensive assistance of at least 1 person for bed mobility, transfers, dressing, toilet use and personal hygeine. He was also coded as being frequently incontinent of urine and always incontinent of bowels. Record review of Resident #2's care plan on 9/2/20 at 3:38 pm, and dated as Effective: 07/27/2020-Present, revealed the facility had approaches in place to address Resident #2's incontinence and maintain maximum control of bladder. The number of incontinent episodes will be reduced over the next 90 days. STATUS: Active (Current).Some of the interventions read as follows: Check for incontinence; change i wet/soiled. clean skin with mild soap and water. Apply moisture barrier. STATUS: Active (Current). Evaluate incontinence pattern to determine voiding schedule. Record output per shift. STATUS: Active (Current). Observation on 9/2/20 at 1:05 pm revealed CNA A had a prepared and clean overbed table with supplies for Resident #1's incontinent care already set up upon entry to the room. CNA A washed her hands and closed the privacy curtain and the door to the room. CNA A, then put on her gloves without sanitizing or re-washing her hands. CNA A removed Resident #1's soiled brief by rolling and folding down the front flap to his brief and tucking it under his testicles. CNA A removed and discarded her gloves and then washed her hands for less than 20 seconds. CNA A returned to the bedside, changing her gloves with difficulty. CNA A used one wipe to dab and blot around the head of Resident #1's penis. She did not retract the foreskin and said, this is hard and it does not pull back. when asked if she was commenting on the fact that she could not retract the foreskin on Resident #1's penis, she replied, Yes. When asked what she does in that instance, she said they know already. When asked if this would be something she would report to the charge nurse, she said they know already and that Resident #1's foreskin had always been like that. CNA A then folded the same wipe and wiped in between the creases and folds of Resident #1's left and right thighs. CNA A then removed and discarded her gloves and reapplied gloves without sanitizing her hands and rolled Resident #1 to his left side. CNA B assisted by helping to hold Resident #1 on his side, while CNA A began to apply a barrier cream to Resident #1's buttock without first clealing the resident. CNA A was about to roll Resident #1 to his right side and had completely removed the soiled brief and discarded it. When asked why CNA A had not cleaned Resident #1's bottom before applying barrier cream, she replied, Oh, I forgot. CNA A then used one wipe to clean Resident #1's entire buttocks and rectum. Observation on 9/2/20 at 1:40 pm of CNA B assisting Resident #2 with incontinent care. CNA B was observed not washing her hands as she entered Resident #2's room and she put on gloves. Resident #2's privacy curtain was pulled very close to the table which had been set up with the new clean brief and wipes. The privacy curtain was observed touching the new clean brief and wipes. Resident #2 was observed being addressed as 'baby' and by his surname by CNA B during incontinent care. After cleaning Resident #2's genital area in the front, Resident #2 was rolled to one side to remove the soiled brief. After removing Resident #2's soiled brief, CNA B did not perform hand hygiene or change her gloves. Resident #2 was rolled onto his back and CNA B dropped one of the clean gloves onto Resident #2's bed. CNA B picked up the clean glove from the resident's bed and applied the glove to her hand. Interview on 9/2/20 at 2:45 p.m, the Administrator said the CNA's had been trained and all should have had competencies on incontinent care. She said that the staff also complete monthly CBT's. The Administrator said that they were planning in completing a skills fair and that the skills fair are ususally completed prior to annual survey. She said that they had recently hired a staffing educator. Requested skills checklists and or competencies for CNA A and B and Administrator was uanble to provide prior to exit. Record review on 9/2/20 at 3:00pm of facility in-service dated 3/26/20 and titled. Infection Control read in part, .3. Wash hands: c. Before and after peri care + diaper ^ . (^ symbol means change). Further record review revealed no observations of either CNA A or CNA B's signatures

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.