STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675061	A. BUILDING _____ B. WING _____	**06/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MUNDAY NURSING CENTER	**421 WEST F ST MUNDAY, TX 76371**

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** - Many	**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 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, in that: a)Nursing and Laundry staff did not handle, process and transport soiled and clean linens in a sanitary manner. CNA #1 carried unbagged soiled bed linens against her body as she walked down a corridor. Laundry staff #1 handled and processed soiled linen without wearing protective clothing and did not wash her hands in a sanitary manner between soiled and clean duties, b)There was no relative negative air pressure in use on the soiled side of the laundry during processing and storage of soiled linens, and c) Staff failed to consistently use good hygienic practices while feeding Resident #1. The DON was handling her cloth face mask and exposing her nose while feeding Resident #1. She failed to consistently use hand hygiene between contact with her mask and feeding the resident. These problems could result in the spread of infections in the facility. The findings include: ~ Linen Transport Issues - Nursing Staff: On 6/1/20 at 11:00 AM CNA #1 was observed walking in the corridor near room [ROOM NUMBER] and carrying a bundle of unbagged soiled bed linens against her chest and shoulder. On 6/1/20 at 1:14 PM an interview was conducted with CNA #1 regarding her handling of soiled bed linens. She stated, Normally soiled is put in a trash bag and then a barrel and we change our gloves. She added, When COVID started, we had an in-service on linen infection control. Regarding the residents whose bed linen she carried earlier, she stated, They don't sleep under that, they mostly on top of the bedspread with a throw. ~ Linen Infection Control Issues - Laundry: On 6/1/20 at 11:15 AM an observation was made of the laundry. Laundry staff #1 was observed placing a bag of soiled linen in a barrel on the soiled side of the laundry. She then began folding and laying out clean clothing on the clean side of the laundry. Laundry staff #1 failed to wash her hands between handling the soiled bag of linen and folding the clean laundry/clothing. Laundry staff #1 then donned a pair of gloves and began loading soiled linen from a barrel into a washer. She was not wearing any protective clothing (gown/apron, etc.). As she leaned into the barrel to retrieve soiled linens, the front of her shirt contacted the soiled interior of the barrel. After loading the washer, Laundry staff #1 washed her hands. After washing her hands, she re-contaminated her hands by handling the contaminated knobs of the handsink as she turned the water off. She then dried her hands and next changed out the plastic liner in the soiled linen barrel. She took the soil barrel outside and returned to the laundry and washed her hands. Again, Laundry staff #1 re-contaminated her hands after washing them by handling the soiled knobs on the hand sink to turn off the water. She then dried her hands and went to a dryer and unloaded clean dry linens into a basket. She then began folding clean clothing. As she folded the clean clothing, she contacted the contaminated front of her shirt. On 6/1/20 at 11:20 AM Laundry staff #1 was asked how long she had worked in the laundry. She stated that she had worked in the laundry for two years. She was then asked what type of training she had received related to the laundry. She stated The lady I replaced walk me through. She walked me through a couple of shifts. On 6/1/20 at 11:30 AM Laundry staff #1 was asked if she had received any in-service or retraining related to handling of linens and laundry. She stated that she had not received any retraining since she started working in the laundry. And additional observation in the laundry revealed that there was no relative negative air pressure provided on the soiled side of the laundry as Laundry staff #1 was processing soiled laundry. Two of two exhaust fans were not turned on. On 6/1/20 at 11:27 AM Laundry staff #1 was asked if she had used the exhaust fans while processing laundry. She stated, I never used it. Meaning that she had not turned them on. Also, at the same time the Administrator stated that she had not been told about using the exhaust fans in the laundry. It was also noted at this time that one of the two exhaust fans were operational once turned on and that the other was unplugged from an electrical outlet. ~ Hand Hygiene Issues and PPE: On 6/1/20 at 12:58 PM the DON was observed feeding Resident #1 in his room with her nose was exposed outside of her cloth face mask. She was also observed adjusting and handling the front of her mask repeatedly as she fed the resident without using hand hygiene. On 6/1/20 at 1:49 PM the DON was interviewed regarding her nose being exposed from her face mask and her handling the face mask while feeding the resident. She stated, I knew it (mask) kept slipping down. Record review of the facility policy labeled Personal Protective Equipment - Using Facemask, Level One, Revised September 2010, revealed the following documentation, Purpose. To guide the use of masks . Miscellaneous . 2. Be sure the facemask covers the nose and mouth while performing treatment or services for the patient . 6. Do not remove the mask while performing treatment or services for the patient . 8. Handle mask only by the strings (ties). 9. Never touch the mask while it is in use . ~ Policy: Record review of the facility policy labeled Infection Control Guidelines For All Nursing Procedures, Revised August 2012 revealed the following documentation, Purpose. To provide guidelines for general infection control while caring for residents . General guidelines 3. Employees must wash their hands for 10 to 15 seconds using anti-microbial or non-anti-microbial soap and water under the following conditions . c. After handling items potentially contaminated with blood, body fluid, or secretions . 5. Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials . Record review of the facility policy labeled Handwashing/Hand Hygiene, Revised August 2015, revealed the following documentation, Policy Statement. This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation . 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 9. The use of gloves do not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene Is recognized as a best practice for preventing healthcare associated infections . Procedure. Handwashing . 3. Dry hands thoroughly with paper towels and then turn off faucet with a clean, dry paper towel. 4. Discard towels into trash . Record review of the facility policy labeled Standard Precautions, Revised December 2007, review the following documentation, Policy Statement. Standard precautions will be used in the care of all residents regardless of their diagnosis, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Policy Interpretation and Implementation . Standard precautions include the following practices . 7. Linen. a. Handle, transport and process used linen soiled with blood, body fluids, secretions, excretions in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and avoids transfer of microorganisms to other residents and environments .

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