STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455412	A. BUILDING _____ B. WING _____	**05/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BROOKHAVEN NURSING AND REHABILITATION CENTER	**1855 CHEYENNE CARROLLTON, TX 75010**

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 ensure the facility established and maintained 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 two (Resident #1 and Resident #2) of three residents reviewed for infection control practices during incontinence care. 1. CNA C and CNA D failed to perform hand hygiene, change gloves and use a clean wipe after one was soiled while providing incontinence care for Resident #1. 2. CNA A and CNA B failed to perform hand hygiene and change gloves at the appropriate times while providing incontinence care for Resident #2. These failures could affect the residents by placing them at risk for the spread of infection. Findings included: 1. Review of Resident #1's face sheet dated 05/13/20, revealed a 77- year- old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's MDS assessment dated [DATE] revealed Resident #1 required extensive assistance with most ADLs. Resident #1 was always incontinent of bowel and bladder. Observation of incontinence care for Resident #1 on 05/13/20 at 11:30 a.m. revealed CNA C and CNA D washed their hands and donned gloves before the start of care. CNA C removed the resident's soiled brief and wiped from front to back. Resident #1's brief was soiled with urine and fecal matter. CNA C used one wipe to make 7 [MEDICAL CONDITION] of cleaning the resident. The wipes and gloves were visibly soiled, but she continued to turn it over after each wipe. CNA C did not wash her hands, change gloves/wipes or perform hand hygiene. CNA C changed gloves before retrieving the clean brief and fastened to the resident. She picked up the trash and walked out of the room without washing her hands. Meanwhile, CNA D was assisting CNA C to provide care to Resident #1. She used the same gloves for repositioning during care and fastened the clean brief to the resident. Additionally, she walked out of the room with gloves on without washing hands or performing hand hygiene. In an interview on 05/13/20 at 11:43 a.m. with CNA C, she said she had been employed in the facility for 18 months and received infection control training last month. CNA C stated cross contamination meant mixing clean with dirty. CNA C acknowledged she should have changed wipes during care and washed hands before exiting the resident's room She added Resident #1 could get sick for not following good infection control practice. Interview with CNA D on 05/13/20 at 11:46 a.m. revealed she had been employed in the facility for about 6 years. She said cross contamination was transferring germs from one place to another. CNA D acknowledged she should have changed gloves and washed hands before leaving Resident#1's room. She received infection control training about 1 month ago. 2. Review of Resident #2's face sheet dated 05/13/20, revealed a 79- year- old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #2's new admission report dated 05/12/20 revealed she was admitted less than 24 hours to the facility. There was no MDS assessment. However, the report indicated the resident required extensive assistance with most ADLs and one-person physical assistance with transfers. Observation of incontinence care for Resident #2 on 05/13/20 at 10:31 a.m. revealed CNA A and CNA B washed their hands and donned gloves before the start of care. Both removed Resident #2's brief. It was soiled with urine and fecal matter. CNA A wiped resident from front to back. She changed her gloves, repositioned the resident and continued to clean the resident. CNA A did not washed hands, change gloves or perform any hand hygiene before retrieving the clean brief and fastening it to Resident #2. Meanwhile, CNA B was assisting in providing incontinent care to Resident #2. She helped to remove the resident's soiled brief and fastened the clean one without washing hands or changing gloves. In an interview on 05/13/20 at 10:42 a.m. with CNA A, she said she had been employed in the facility for 8 months. CNA A acknowledged she should have washed hands or changed gloves before placing the clean brief under Resident #2 and fastening it. CNA A stated she had infection control training 2 months ago. CNA A said the resident could acquire an infection when she did not perform hand hygiene. During an interview with CNA B on 05/13/20 at 10:48 a.m., she said she had been employed in the facility for 6 years. CNA B explained cross contamination was mixing dirty with clean. She acknowledged not changing gloves was not a good infection control practice. CNA B stated failure to follow correct infection practices may result in the residents having all types of infections. During an interview with the DON on 05/13/20 at 3:31 p.m., he acknowledged he was aware of some of the concerns raised about infection control. He stated the aides knew what to do but must have been nervous while providing care in the presence of a surveyor. The facility's hand washing/hand hygiene policy revised July 2014 reflected, .this facility considers hand hygiene the primary means to prevent the spread of infection . Some of the policy interpretation and implementation includes: 1) All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections 2) 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 (antimicrobial or non-antimicrobial) and water for the following situations: a) When hands are visibly soiled: and b) After contact with a resident with infections diarrhea including, but not limited to infections caused by norovirus, salmonella, shigella and [DIAGNOSES REDACTED]icile

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