STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676395	A. BUILDING _____ B. WING _____	**03/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HEALTHCARE RESORT OF PLANO	**3325 WEST PLANO PARKWAY PLANO, TX 75075**

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 -** Few	**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 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 for 1 (Resident #1) of 2 residents reviewed for infection control practice. CNA A failed to perform hand hygiene and change gloves at the appropriate times while providing incontinence care for Resident #1 These failures could affect residents by placing them at risk for the spread of infection. Findings included: Review of Resident #1's face sheet dated 03/18/20, revealed he was a 91- year- old male admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#1's MDS assessment dated [DATE] revealed Resident #1 required extensive assistance with most activities of daily living(ADLs)and two-person physical assistance with transfer. Resident #1 was always incontinent of bowel and bladder. Review of Resident #1 Care Plan undated revealed he has bowel and bladder incontinence related to impaired mobility, pain, cognitive deficit and use of diuretics. Observation on 03/17/20 at 2:20 p.m. revealed Resident #1 was receiving incontinence care from CNA A and CNA B. CNA A did not wash hands but donned gloves before starting care. CNA B washed her hands and put on gloves. CNA A transferred Resident #1 from wheelchair to bed. He did not wash his hands, change his gloves or perform hand hygiene before he unfastened Resident #1's soiled brief. Resident #1's brief was soiled with urine and fecal matter. CNA A cleaned Resident #1's peri area and buttocks. CNA A's gloves were visibly soiled, but he retrieved Resident #1 clean brief and placed it on the bed. CNA A proceeded to assist CNA B in fastening Resident #1's clean brief. CNA A washed his hands before exiting the resident's room. During interview with CNA A on 03/17/20 at 2:35 p.m., he said he had been employed in the facility for six months and received infection control training during orientation. CNA A explained cross contamination was mixing dirty with clean. He acknowledged not washing his hands, changing gloves or performing hand hygiene while providing incontinence care to Resident #1. CNA A stated failure to follow infection control practices may result in the residents having all types of infections. During an interview with the DON on 03/18/20 at 12:05 p.m., he acknowledged he was aware of some of the concerns raised about infection control. He explained he expected the aides to wash their hands and change gloves according to regulation and facility policy while providing care to the residents. The facility's hand washing policy revised May 2007 reflected, It is the policy of this facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. Some of the procedures includes: 1) Wet hands and apply soap to hands from soap dispenser 2) Run hands in circular motion for not less than fifteen (20) seconds 3) Rub fingers between fingers for fifteen (20) seconds 4) Rinse hands with warm water 5) Dry hands with paper towel 6) Turn off faucet with paper towel 7) Discard paper towel in appropriate receptacle

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