STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455727	A. BUILDING _____ B. WING _____	04/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PARK MANOR HEALTH CARE AND REHABILITATION	207 E PARKERVILLE RD DESOTO, TX 75115

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.** Based on observation, interview and record review, the facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling infections for two (Residents #1 and Resident #2) of five residents reviewed for infection control practices. 1) The facility failed to ensure LVN A and Resident #1 were screened for COVID-19 and wearing a face mask when returning to the unit with Resident #1. This failure is related to COVID-19 response. 2) The facility failed to ensure LVN A and CNA B performed hand hygiene before donning gloves and transferring Resident #2 into her wheelchair. These failures could place resident at risk for the spread of infectious diseases. Findings included: 1) An observation from the receptionist desk, during COVID screening, on 04/23/20 at 8:35 AM revealed LVN A and Resident #1 entered the facility, walked past the front desk back to the unit; neither wearing a mask. The DON had completed her screening first and was at the receptionist desk when LVN A and Resident #1 walked in the facility. An interview with LVN A on 04/23/20 at 11:24 AM revealed he was the charge nurse on hall 100 south. He stated when he was coming in the facility that morning, he was bringing Resident #1 into the building. He stated he had just picked Resident #1 up from a nearby motel where he used to live before admitting to the facility. He stated Resident #1 was mentally competent and could go on pass alone, but they were not allowing residents to leave the facility right now. He stated Resident #1 failed to sign out or notify staff that he wanted to leave. LVN A stated he contacted Resident #1's mother to find Resident #1, but she was at work. LVN A stated he knew because she told him before that Resident #1 used to live at a motel. He stated he found Resident #1 sitting outside of the motel and brought him back to the facility. He stated he had already been at the facility that morning and he assessed Resident #1 once they made it to Resident #1's room. An interview with Resident #1 on 04/23/20 at 2:56 PM revealed he went to the motel where he used to live before coming to the facility that morning. He stated he just wanted to go. Resident #1 stated he left out of the back gate and did not tell anyone he was leaving. He stated it took him two hours to walk there and he was there about 15 minutes by the time LVN A came to pick him up. He stated he did not have contact with anyone while he was there and just smoked a cigarette. He stated when they made it back to the facility, LVN A did not assess him. He stated LVN A just dropped him off at his room and left. Review of Resident #1's MAR indicated [REDACTED]. Review of the COVID-19 screenings dated 04/23/20 reflect LVN A was screened once that day; no time indicated. An interview with the ADM on 04/23/20 at 9:16 AM revealed staff were not allowed to leave the premises until after their shift was over. She stated all staff and visitors must sanitize their hands at the entrance and go through screening with a temperature check before being allowed to enter the facility. A follow-up interview with the ADM on 04/23/20 at 3:04 PM revealed she was notified by the DON at about 7:30 AM that morning that Resident #1 had left the facility. She stated the DON called and told her that she found him at the motel where he used to live and called LVN A to the motel to pick him up. She stated since LVN A left the building, he should have gone back through screening before going back to the unit. An interview with the DON on 04/23/20 at 3:33 PM revealed she found Resident #1 sitting on a post outside of the motel where he used to live. She stated he was sitting alone and she did not see him make contact with anyone. The DON stated she stayed in her car and watched him until LVN A arrived and transported him back to the facility. She stated LVN A should have gone back through screening when he entered the facility. The DON stated LVN A was probably trying to get Resident #1 back to his room. Review of the facility's COVID, Prevention and Control dated 03/02/20 reflected, .Facility will establish one central point of entrance for screening and signing in/out procedures. Screenings should be completed by a nurse and/or designee and signed by each person being screened .Facility staff, any essential health care personnel, and visitors will sign in/out, perform hand hygiene, be screened at the facility central entrance location . Review of the CDC's guidelines for Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs), dated 04/15/20, reflected: 1. Keep COVID-19 from entering your facility . Actively screen anyone entering the building (HCP, ancillary staff, vendors, consultants) for fever and symptoms of COVID-19 before starting each shift; send ill personnel home. Sick leave policies should be flexible and non-punitive 3. Prevent spread of COVID-19: Actions to take now. Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments . 2) An observation of Resident #2's Hoyer lift transfer from her bed to her wheelchair on 04/23/20 at 11:02 AM revealed LVN A and CNA B performed the transfer. CNA B removed a pair of latex gloves from her pocket, donned them, and began moving the Hoyer lift into Resident #2's room. LVN A was in the doorway and asked CNA B if she needed help; she agreed. LVN A came into the room and donned gloves (neither staff person was observed performing hand hygiene before donning their gloves). The staff were observed transferring Resident #2 from her bed to her wheelchair. LVN A went to Resident #2's bathroom first, washed his hands, and left the room. After CNA B finished putting on Resident #2's shoes, she went to Resident #2's restroom, washed her hands, and left the room. An interview with Resident #2 on 04/23/20 at 10:46 AM revealed she required hands-on assistance from staff with ADL care. She stated many times staff wore gloves, but she never heard or saw staff go into her restroom and wash their hands when they provided care to her. She stated it was possible that staff washed their hands somewhere else, but not in her room. A follow-up interview with the ADM on 04/23/20 at 3:04 PM revealed she was advised of the transfer of Resident #2. She stated the staff should have been doing hand hygiene before and after resident contact. An interview with the DON on 04/23/20 at 3:33 PM revealed she was advised of the process of Resident #2's Hoyer lift transfer. The DON stated staff should do hand hygiene before and after resident care of any kind. Review of the facility's Infection Control Guidelines for Nursing Procedures policy dated August 2012 reflected, Employees must wash their hands for ten (10) to fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: a. Before and after direct contact . In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub .for all the following situation: a. Before and after direct contact with residents; b. Before donning sterile gloves .

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.