STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676039	A. BUILDING _____ B. WING _____	**04/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINTERS PARK NURSING AND REHABILITATION CENTER	**3737 N GARLAND AVENUE GARLAND, TX 75044**

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 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 for one (Resident #1) of one residents observed for infection control. RN A and CNA B failed to perform hand hygiene between glove changes during care and at the end of care for Resident #1. This failure placed residents at risk of cross-contamination and infections. Findings included: Review of Resident #1's Admission Record, dated 04/01/20, revealed he was a [AGE] year-old male re-admitted to the facility on [DATE]. Resident #1's active [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan, dated 04/01/20, revealed he had an activities of daily living deficit and required the minimum assistance of one staff member for turning and repositioning in bed. The care plan further revealed Resident #1 required extensive assistance of one staff member with toileting. During an observation of Resident #1's nursing admission assessment on 04/01/20 at 1:20 PM, RN A removed the blood pressure cuff from Resident #1's arm and then removed her gloves. RN A applied a pair new pair of gloves, without performing hand hygiene after doffing and before donning a new pair of gloves. RN A wrote something down on a piece of paper on the resident's bedside table and then removed her gloves. RN A applied a new pair of gloves without performing hand hygiene and obtained Resident #1's temperature. RN A removed her gloves and exited the room to assist RN E who was assembling a wheelchair from storage. RN A then re-entered Resident #1's room and applied a new pair of gloves without performing hand hygiene. Observation on 04/01/20 at 1:30 PM, RN A and CNA B log rolled Resident #1 to his left side, exposing his bare buttock area. RN A placed her gloved right hand on Resident #1's bare right buttock area to check Resident #1's coccyx area. While CNA B was supporting resident positioning to his left side, RN A placed her stethoscope bell to posterior area of Resident #1's chest. RN A failed to perform hand hygiene and change gloves after touching Resident #1's buttock area and before touching her stethoscope and Resident #1's posterior chest area. RN A then raised Resident #1's gown and visually inspected Resident #1's genital area. RN A grasped Resident #1's scrotal area with her gloved right hand and repositioned the scrotal sac up and to the left, visually inspecting to the perineum area. Without performing hand hygiene or changing gloves, RN A touched Resident #1's right arm and placed her right gloved hand on Resident #1's neck, stating that she saw Resident #1's stitches. During an observation of Resident #1's incontinence care on 04/01/20 at 1:36 PM, Resident #1 was log rolled to his left side with the assistance of RN A and CNA B. RN A placed a brief under Resident #1's buttock area and then with her gloved right hand used wipes to clean Resident #1's rectum, gluteal folds, and buttocks. RN A, with the same gloved right hand that wiped Resident #1's rectum, gluteal folds, and buttocks, placed her right gloved hand on Resident #1's shoulder, within close proximity to his face and neck stitches. CNA B asked CNA C to bring her additional gloves. CNA C brought her additional gloves and CNA B removed her current pair of gloves and donned a new pair without performing hand hygiene. CNA B then finished cleaning Resident #1's rectum, gluteal folds, and buttock area and then applied a brief to Resident #1 while wearing soiled gloves. Once incontinence care of Resident #1 was completed, RN A then doffed her gloves without performing hand hygiene and picked up a piece of paper (COVID -19 screening form) from the bedside table for Resident #1 to sign. Resident #1, attempting to steady the surface, reached out with his non-dominant hand and grasped RN A's bare, flat palmed, hand that was not properly sanitized after incontinence care. Resident #1 then signed the COVID-19 screening form. RN A washed her hands in Resident #1's restroom but failed to offer hand hygiene to Resident #1. In an interview with RN A on 04/01/20 at 2:18 PM, she stated it was not necessary to change gloves and perform hand hygiene unless she touched bodily fluids. RN A stated she should have changed gloves after assessing Resident #1's scrotum and before assessing and handling Resident #1's upper body, including the exposed stitches on his neck. RN A stated that it was important to perform proper hand hygiene, so infections were not transmitted to and from residents. In an interview with CNA B on 04/01/20 at 2:43 PM, she stated that she had been instructed to use hand sanitizer in between glove changes. CNA B stated she did not perform hand hygiene during Resident #1's incontinence care because her hands were clean in the gloves, and there was no need to perform hand hygiene in that particular situation. CNA B stated the importance of hand hygiene was to prevent infection and to protect the resident. In an interview with the facility's Corporate Nurse on 04/09/20 at 2:51 PM, she stated her expectations were for staff to perform hand hygiene before and after donning and doffing gloves. She stated her expectations were for staff to change gloves and perform hand hygiene after staff touched the perineal area and before staff touched a resident's stitches. She then stated if hand hygiene was not performed properly, cross contamination could occur and infections could be spread. In an interview with the facility's ADON/Infection Preventionist, RN E, on 04/01/20 at 3:07 PM, she stated her expectations were for staff to perform hand hygiene before, in between, and after glove changes, and after care. She stated, with any glove change, hand hygiene needs to be performed. She stated it was her expectation that staff were to change gloves and perform hand hygiene when going from perineum area to anywhere else. RN E then stated that if hand hygiene was not performed properly, there was a risk of transmitting infections to her residents. In an interview with the facility's DON, on 04/01/20 at 3:22 PM, she stated her expectations were for hand hygiene to be performed before and after donning and doffing gloves and in between glove changes. She then stated Resident #1 was at an increased risk as he was a [MEDICAL TREATMENT] resident and is immunocompromised. The DON then stated Resident #1 was admitted to the hospital for infection as his [MEDICAL TREATMENT] catheter was infected and he became septic. The DON stated he recently had his [MEDICAL TREATMENT] catheter replaced as the previous one was infected. The DON stated there was a risk of contamination if hand hygiene was not followed. In an interview with the facility's Executive Director, on 04/01/20 at 4:02 PM, he stated he expected his staff to practice good hand hygiene and infection control practices. He further stated he expected staff to always perform hand hygiene in between glove changes. He stated there was a risk of spreading infection if proper hand hygiene was not performed correctly. Review of the facility's Hand Hygiene policy revised August 2015 revealed, .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors Policy 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .b. Before and after direct contact with residents .g. Before moving from a contaminated body site to a clean body site during resident care . i. After contact with a resident's intact skin . j. After contact with blood or bodily fluids .l. After contact with objects (e.g. medical equipment) in the immediate vicinity of the resident .m. After removing gloves.

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