STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455651	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DOWNTOWN HEALTH AND REHABILITATION CENTER	**424 S ADAMS ST FORT WORTH, TX 76104**

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, 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 and infections for four (Residents #1, #2, #3, and #5) of 17 residents reviewed for infection control. CNA A failed to perform appropriate hand hygiene between rooms while delivering lunch trays to Residents #1, #2, #3, #5 in their rooms. This failure could affect residents in a COVID postive facility by resulting in the spread of infection. Findings included: Observation on 05/15/2020 at 10:44 AM revealed the hall with rooms 237- 238, had intermittently placed hand sanitizer holders (for dispensing hand santizer from up-side down foaming can dispensers) on walls, but no hand sanitizer cans in holders. In hall with rooms 200-213, two holders were observed with cans. One did not contain santizer, and the other one did. Observation of the non-isolation hall on 05/15/20 at 11:45 AM revealed CNA A pushed the cart holding lunch trays to the door of a resident's room and delivered lunch trays to Residents #1 and #2, without using sanitizer or washing hands before picking up the first tray, between presenting trays to each resident, or upon exiting the room. CNA A then proceeded to push the cart a short distance, and without sanitizing or washing hands, removed another tray from the cart and entered a resident room to deliver the tray to Resident #3, and exited the room without washing her hands or using sanitizer. CNA A then removed another tray from the cart and knocked on the door of a resident's room with her knuckles, opened the door and entered the room, leaving the tray for Resident #5. Afterwards she pulled the door closed, without washing or sanitizing her hands, and started to push the cart again. An interview on 05/15/20 at 11:48 AM with CNA A revealed she was supposed to wash or sanitize her hands between each tray she delivered, but there was no sanitizer in the hall. She said they were supposed to wash if they did not have sanitizer. The facility did have plenty of soap and paper towels. She was just trying to get the food to people as quickly as she could. An interview on 05/15/20 with Resident #1 revealed she had been in the hospital, and was very recently moved out of the isolation hall, and into her usual room. She said she thought they did OK on her current hall, and sanitized their hands enough, but she could not see what they were doing out in the hall. She said staff did not use the protection that the COVID isolation hall did, where they were really on it. An interview on 05/15/20 at 12:02 PM with Medical Records clerk revealed corporate sent them hand sanitizer and supplies now, but they did not have enough of the type of sanitizer needed for the wall units until very recently they got a case. She typically replenished the hand sanitizer dispensers every Friday, which was enough because they lasted about a week to a week and a half. She said that on the previous Friday, they did not have enough, and she had to prioritize the dispensers in the isolation hall. She was observed at this time replenishing the dispensers in the 200 hall where the aide was observed not [MEDICATION NAME] proper hand sanitation earlier that morning. An interview on 05/15/20 at 12:11 PM with LVN C revealed they were supposed to perform hand hygiene before and after any resident contact. She said they were low on hand sanitizer in the wall dispensers, but they did have sanitizer at the nurses' station. LVN C stated there were two bathrooms in the hall, in addition to the resident rooms, and they had plenty of soap and towels to wash hands. She said she did see staff using the bathrooms, and the hand sanitizer at the station, sometimes. An interview on 05/05/20 at 12:57 PM with the Administrator revealed they had been out of the refills for the wall hand sanitizer dispensers for a while because they had trouble getting that kind, but they did have smaller bottles at the nurses station which they refilled from gallon containers. He said they had those at the nurses station, and an abundance of soap and water in all the bathrooms which the staff should have used when delivering trays. He said it was wrong of them to not use it, even if they were busy. He said they had been doing training on infection control and hand sanitization continually since March 2020. Review of in-service records reflected CNA A was in-serviced on the following dates on subjects relevant to hand hygiene: 03/18/20- COVID-19 and handwashing 05/14/20- Proper handwashing, and wearing a mask at all times during the shift Review of the facility's Hand Hygiene policy, undated, reflected Purpose: To decrease the risk of transmission of infection by appropriate handy hygiene. Policy: Handwashing/hand hygiene is generally considered the most important single procedure for preventing healthcare associated infections. (.) Using an alcohol based hand rub is appropriate for decontaminating the hands before direct patient contact, (.) before eating, and after contact with inanimate objects in the patient's environment.

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.