STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675281	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COTTONWOOD CREEK HEALTHCARE COMMUNITY	**1111 W SHORE DR RICHARDSON, TX 75080**

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 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 eight (Resident #1, #2, #3, #4, #5, #6, #7, and #8) of eight resident who tested positive for the flu. The facility failed to make the required report to the State Survey Agency when they had eight residents with reported positive flu tests within a two-day period. This failure placed residents at risk for infections. Findings included: Review of the facility's antibiotic stewardship book on 03/10/20 revealed there were eight residents that tested positive for the flu on February 8th and 9th, 2020. The residents date of symptom onset was the following: 02/08/20 - Resident #2, #6, #7, and #8 02/09/20 - Resident #1, #3, #4, and #5 Record review revealed there were no current active cases of the flu during the time of the visit. Interview on 03/10/20 at 2:10 PM with the DON revealed they had residents with the flu last month (February 2020) and they called the local health department but did not call in to the State Survey Agency because they were told by the health department they would call it in if they had more cases. She stated there must have been some miscommunication. Interview on 03/10/20 at 3:25 PM with the DON revealed she was not aware their flu situation needed to be reported to the State Survey Agency.

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.