STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676293	A. BUILDING _____ B. WING _____	**04/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONARCH PAVILION REHABILITATION SUITES	**6825 HARRY HINES BLVD DALLAS, TX 75235**

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 nine (Residents #1, #2, #3, #4, #5, #6, #7, #8, and #9) of ten residents observed for infection control. CNA A failed to practice proper hand hygiene when passing ice to Residents #1, #2, #3, #4, #5, #6, #7, #8, and #9. The failure placed residents at risk for infection. Findings included: Observation on 04/18/20 at 11:02 AM revealed CNA A passing ice to residents. CNA A was observed passing ice to Residents #1 and #2. Observation revealed CNA A brought two ice pitchers from the residents' room, placed the two pitchers on her cart, removed the lids and set the lids on the cart. CNA A scooped ice into each pitcher, replaced the lids, and returned the pitchers to the residents' bedsides. CNA A did not perform hand hygiene before or after entering or exiting the residents' room or handling their water pitchers. Observation on 04/18/20 at 11:07 AM revealed CNA A took the pitcher from Resident #3's room. Observation revealed CNA A scooped ice into the pitcher and took the pitcher into Resident #3's room. CNA A did not perform hand hygiene before or after entering or exiting the resident's room or handling their water pitcher. Observation on 04/18/20 at 11:09 AM revealed CNA A knocked on Resident #4's door. Observation revealed CNA A removed the water pitcher from Resident #4's beside table, emptied the pitcher in the resident's bathroom, and took the pitcher to her cart in the hall. CNA A was observed scooping ice into the pitcher and returning it to Resident #4's bedside. CNA A did not perform hand hygiene before or after entering or exiting the residents' room or handling their water pitcher. Observation on 04/18/20 at 11:12 AM revealed CNA A knocked on Resident #5's door. Observation revealed CNA A retrieved the water pitcher from Resident #5's room. CNA A placed the pitcher on her cart, filled it with ice, and returned the pitcher to the resident's bedside. CNA A did not perform hand hygiene before or after entering or exiting the resident's room or handling their water pitcher. Observation on 04/18/20 at 11:14 AM revealed CNA A removed the water pitcher from Resident #6's room. CNA A filled the pitcher with ice and returned the pitcher to the resident's bedside. CNA A did not perform hand hygiene before or after entering or exiting the residents' room or handling their water pitcher. Observation on 04/18/20 at 11:15 AM revealed CNA A knocked on the door of Resident #7's room. Observation revealed CNA A retrieved the water pitcher from Resident #7's bedside. CNA A set the pitcher on her cart, held the lid to the pitcher in her left hand, and scooped ice into the pitcher. CNA A placed the lid back on the pitcher and returned the pitcher to the resident's bedside. CNA A did not perform hand hygiene before or after entering or exiting the residents' room or handling their water pitcher. Observation on 04/18/20 at 11:16 AM revealed CNA A standing inside Resident #8's room. Observation revealed CNA A removed her eyeglasses and then placed them back on her face. CNA A did not perform hand hygiene after touching her glasses or upon exiting the resident's room. Observation on 04/18/20 at 11:18 AM revealed CNA A knocked on Resident #9's door. CNA A was observed taking the resident's water pitcher to the bathroom to empty it. CNA A returned to her cart where she placed the pitcher on her cart and filled the pitcher with ice. CNA A returned the pitcher to Resident #9's bedside. CNA A did not perform hand hygiene before or after entering or exiting the residents' room or handling their water pitcher. Interview with CNA A on 04/18/20 at 11:20 AM revealed she had worked at the facility for four months. CNA A stated she did not typically perform hand hygiene or wear gloves while passing ice to residents. CNA A stated she had not been instructed to wear gloves or perform hand hygiene when passing ice. CNA A denied concerns with the method she had used to pass ice to residents. CNA A stated potential consequences of touching multiple residents' personal items without performing hand hygiene was it could potentially spread bacteria and people could get sick. CNA A stated hand sanitizer was readily available for her to use. CNA A stated there was no reason for her not to sanitize her hands throughout the process of passing ice to resident rooms. Interview with ADON on 04/18/20 at 5:29 PM revealed the expectation was for staff to perform hand hygiene anytime the staff member came in contact with a resident's personal items. ADON stated gloves were not required to pass meals or ice, but that staff were expected to perform hand hygiene between each resident when performing these tasks. ADON stated staff were to at minimum, use hand sanitizer between the first two residents and perform hand washing following contact with a third resident's items. ADON stated residents' water pitchers were not to be set on the ice cart. ADON stated the CNA should hold the pitcher in their hand and scoop ice using their free hand. ADON stated placing the pitcher on the cart could lead to cross contamination. ADON stated not performing hand hygiene after touching the resident's pitcher was an infection control issue. ADON stated not performing hand hygiene could potentially lead to the spread of pathogens from one person to another. Interview with DON on 04/18/20 at 5:51 PM revealed staff had been trained to perform hand hygiene before entering and upon leaving a resident's room. DON stated staff were not expected to wear gloves when passing ice to resident rooms as long as the resident was not on isolation. DON stated staff were expected to perform hand hygiene between each resident room when passing ice. DON stated residents' pitchers should not come in contact with the ice cart. DON stated the CNA should hold the pitcher in one hand and scoop ice into the cup with the other hand. DON stated if this procedure was not following, staff could potentially spread contaminants from one room to the next. DON stated failure to perform hand hygiene while passing ice had the potential to spread an infectious organism. Review of facility's current Infection Prevention and Control Policies and Procedures regarding hand hygiene/handwashing revealed the following: Policy: Proper hand hygiene/hand washing technique will be accomplished at all times that handwashing is indicated .Hand hygiene/hand washing is done: Before patient/resident contact .After contact with soiled or contaminated articles .After patient/resident contact .After contact with a contaminated object or source where there is a concentration of microorganisms .After contact with the environmental surfaces in the immediate vicinity of patients/residents .

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.