STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675785	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EDINBURG NURSING AND REHABILITATION CENTER	5215 S SUGAR RD EDINBURG, TX 78539

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, the facility failed to maintain an infection control prevention and control program, including hand hygiene, designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infection, for four Residents (R#2, R#3, R#4, and R#5) of four residents observed for infection control practice, in that: 1) CNA A took the same box of gloves from resident room to resident room. 2) CNA B and LVN C did not don gloves when using Micro Kill Bleach wipes. 3) CNA B did not change gloves or perform hand hygiene when providing incontinent care to R#2. 4) LVN C did not perform hand hygiene between glove change when providing wound care to R#3 5) R#4 and R#5 had oxygen tubing on the floor. The findings were: 1) Observation on 08/04/20 at 11:35 a.m., revealed a box of size medium gloves inside a plastic bag on a chair next to R#1's bed. In an interview, at the time of the observation, CNA A said she took the same box of gloves into each resident's room, putting the box of gloves into a clean bag each time. In an interview on 08/04/20 at 12:05 p.m., the DON said the staff were allowed to take the box of gloves inside a clean bag into the residents' rooms. The DON said there was a possible cross contamination when doing that and staff should leave the box of gloves inside the room. 2) Observation on 08/04/20 at 1:30 p.m., of the COVID positive hallway, revealed CNA B grabbed a Micro Kill bleach wipe and wiped down the hallway phone, with no gloves. In an interview on 08/04/20 at 2:23 p.m., CNA B said she did not wear gloves when using the Micro Kill bleach wipes, unless what she was cleaning was visibly soiled. Observation on 08/04/20 at 1:35 p.m., revealed LVN C grabbed Micro Kill bleach wipes and wiped down the blood pressure cuff, with no gloves. 3) Observation on 08/04/20 at 1:45 p.m. revealed CNA B provided incontinent care to R#2. CNA B cleaned R#2's pubic area, using gloved hands. CNA B then cleaned R#2's buttocks, and removed R#2's soiled brief. Without performing hand hygiene or changing gloves, CNA B proceeded to grab a clean brief and secure it on R#2, using the same soiled gloves she had cleaned R#2 with. In an interview on 08/04/20 at 2:23 p.m., CNA B said she did not change gloves when providing incontinent care. CNA B said she sometimes double gloved, so if the first pair gets soiled, CNA B removed the first pair, and still had the other pair on. Record review of R#2's Admission Record, dated 08/06/20, revealed R#2 was a [AGE] year-old male who was admitted to the facility on [DATE]. R#2's [DIAGNOSES REDACTED]. Record review of R#2's Quarterly MDS assessment, dated 07/11/20, revealed R#2: -had clear speech, -was usually able to make himself understood, -was usually able to understand others, and -required extensive assistance by one staff for bed mobility, transfers, dressing, toilet use, and personal hygiene. 4) Observation on 08/04/20 at 1:56 p.m. revealed LVN C provided wound care to R#3. LVN C opened the skin prep with gloved hands and cleaned R#3's left great toe, then removed gloves. Without washing or sanitizing hands, LVN C donned clean gloves, cleaned R#3's left 2nd toe and removed gloves. Without washing or sanitizing hands, LVN C donned clean gloves, cleaned R#3's left 4th toe, and removed gloves. Without washing or sanitizing hands, LVN C donned clean gloves, cleaned R#3's right great toe. LVN C cleaned the tray with Micro Kill Bleach wipes with no gloves. In an interview, on 08/04/20 at 2:00 p.m., LVN C said she was not sure if she had to change out her gloves or not. LVN C said she should have used hand sanitizer or washed hands between glove changes. LVN C said she did not wear gloves when using the Micro Kill Bleach wipes because gloves were not allowed to be worn in the hallway. Record review of R#3's Admission Record, dated 08/06/20, revealed R#3 was an [AGE] year- old male who was admitted to the facility on [DATE]. R#3's [DIAGNOSES REDACTED]. Record review of R#3's Quarterly MDS assessment, dated 07/16/20, revealed R#3: -had unclear speech, -was rarely/never able to make himself understood, -was rarely/never able to understand others, and -had severely impaired vision. 5) Observation on 08/04/20, at 2:50 p.m., accompanied by ADON/RN D, revealed R#4 was in bed, with a nasal cannula on and connected to the oxygen concentrator. The tubing to the nasal cannula was touching the floor. Record review of R#4's Admission Record, dated 08/06/20, revealed R#4 was a [AGE] year-old female, with an admission date of [DATE] and a re-admitted on 06/06/20. R#4's [DIAGNOSES REDACTED]. Record review of R#4's Quarterly MDS assessment, dated 06/10/20, revealed R#4: -had difficulty hearing (minimal), -had unclear speech, -was sometimes able to make herself understood, and -was sometimes able to understand others. 6) Observation on 08/04/20, at 2:52 p.m. revealed R#5 sitting up in her wheelchair, with a nasal cannula on, connected to the oxygen concentrator. The tubing to the nasal cannula was noted to be touching the floor. In an interview, at the time of the observation, the ADON/RN said the tubing should not be touching the floor. In an interview, on 08/05/20 at 9:50 a.m., the DON said staff should be wearing gloves when using the Micro Kill Bleach wipes. The DON said staff should use hand sanitizer between glove changes and the oxygen tubing should not be touching the floor. Record review of R#5's Admission Record, dated 08/06/20, revealed R#5 was a [AGE] year-old female, with an admission date of [DATE]. R#5's [DIAGNOSES REDACTED]. Record review of R#5's Admission MDS assessment, dated 07/29/20, revealed R#5: -had adequate hearing, -had clear speech, -was able to make herself understood, and -was able to understand others. Record review of facility policy Handwashing - Hand Hygiene revised January 2018 revealed: Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water for the following situations: .m. after removing gloves . the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing health-care associated infections.

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.