

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455904	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024
NAME OF PROVIDER OR SUPPLIER Rowlett Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9300 Lakeview Pkwy Rowlett, TX 75088	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review the facility failed to ensure the right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for one (Resident #78) of eight residents reviewed for reasonable accommodation of needs.</p> <p>The facility failed to ensure the call light system in Resident #78's rooms were in a position that was accessible to the residents.</p> <p>This failure could place the residents at risk of being unable to obtain assistance when needed and help in the event of an emergency.</p> <p>Findings included:</p> <p>Review of Resident #78's Face Sheet, dated 06/19/2024, reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included difficulty walking, unsteadiness of feet, and weakness.</p> <p>Review of Resident #78's Quarterly MDS Assessment, dated 04/19/2024, reflected Resident #78 had a moderate impairment in cognition with a BIMS score of 11. Resident #15 required moderate assistance for upper body dressing and lower body dressing.</p> <p>Review of Resident #78's Comprehensive Care Plan, dated 05/02/2024, reflected Resident #78 was at risk for falls related to poor balance and lack of coordination, and weakness and one of the interventions be sure the call light is within reach and encourage to use it to call for assistance as needed.</p> <p>Review of Resident #78's Joint Mobility Evaluation, dated 05/22/2024, reflected resident had limited range of motion to both shoulders, both elbows, and both wrists.</p> <p>Review of Resident #78's Fall Risk Assessment, dated 05/16/2024, reflected resident had a minimum risk for fall.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with Resident #78 on 06/18/2024 at 11:25 AM revealed that Resident #78 was sitting at the side of her bed. Resident #78's call light was noted pinned between the bed and the wall. Resident #78 reached out her left arm and tried to pull the cord of the call light but stated she cannot pull it because it was trapped between the bed and the wall. She stated that whoever fixed her bed did not notice that the call light could not be accessed and was not able to pull it back to put it on top of the bed. She stated she would use her roommates call light if she needed assistance. She said the staff should put her call light where she could reach it because her arms were not strong enough to pull it.</p> <p>Observation on 06/19/20204 at 7:55 AM revealed that Resident #78 was sitting on her bed talking to a visitor. Her call light was still pinned between the bed and the wall and resident still cannot pull it.</p> <p>In an interview with CNA C on 06/19/2024 at 10:57 AM, CNA C stated she was assigned on Resident #78's hall. CNA C said she did her round at the start of her shift to check if any resident needed to be changed or transferred to the wheelchair. She said she also monitor if the call lights were with the residents. She said she did not notice that Resident #78's call light was pinned between the bed and the wall and cannot be pulled. She said Resident #78 seldom use the call light but said she must still make sure the call light was accessible when needed. She said call light must always be accessible because the residents use them to call the staff for any need and in cases of emergencies. CNA C added that if the call lights were not with the residents, the needs of the resident will not be known and addressed. She said she was responsible in ensuring the call lights were accessible for her assigned residents. She said she would her round and make sure the call lights were accessible to her assigned residents.</p> <p>In an interview with the DON on 06/19/2024 at 11:18 AM, the DON stated the call lights were inside the residents' rooms for a reason. He added the residents used the call lights to call for assistance, for a glass of water, for a pain medication, or for incontinent care. The DON added without the call lights, the residents would not be able to tell the staff what they needed and eventually their needs would not be met. The DON further added when the residents cannot pull or access their call lights, unfavorable incidents like falls, minor hurts, or major injuries could happen. The DON said the expectation was for the staff to ensure that the call lights were within reach of the residents at all times. The DON concluded that moving forward, he would educate the staff of the importance of call lights for the residents and would include the issue on their morning meeting.</p> <p>In an interview with LVN A on 06/20/2024 at 7:32 AM, LVN A stated call lights should be within the reach of the residents at all times. LVN A said the call lights should not be in position where the resident cannot pull it or access it. She said for some residents, the call light was their sense of protection that if something happened to them, they would be able to call the staff for help. She said the residents also use the call lights if they needed to be changed or they needed a pain medication. LVN A said the residents might fall trying to get up and get what they needed. LVN A said everybody was responsible in making sure the call lights were with the residents, whether the resident was independent or not. She said she would check her rooms to see if the residents had their call lights</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of facility's policy Call Light/Bell Policy/Procedure - Nursing Clinical revised 05/2007 revealed, Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff . Procedures . 5 . Place the call device withing resident's reach before leaving room.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>Based on observations, interviews, and record review, the facility failed to ensure that Residents, who needed respiratory care, was provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 2 (Resident #321 and Resident #322) of ten residents reviewed for respiratory care.</p> <p>The facility failed to ensure Resident #321's nebulizer masks and nasal cannula was properly stored.</p> <p>The facility failed to ensure Resident #322's nasal cannula was properly stored.</p> <p>The facility failed to ensure a Physician's Order was in place for Resident #322's oxygen administration.</p> <p>These failures could place the residents at risk for respiratory infection and not having their respiratory needs met.</p> <p>Findings included:</p> <p>Resident #321</p> <p>Review of Resident #321's Face Sheet, dated 06/19/2024, reflected that resident was a [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs) with exacerbation and acute respiratory failure with hypoxia (insufficient amount of oxygen in the body).</p> <p>Review of Resident #321's Comprehensive MDS Assessment, dated 06/08/2024, reflected resident had a severe impairment in cognition with a BIMS score of 07. The Comprehensive MDS Assessment indicated Resident #321's primary medical condition was chronic obstructive pulmonary disease with exacerbation.</p> <p>Review of Resident #321's Comprehensive Care Plan, dated 06/08/2024, reflected resident had an altered cardiovascular status related to COPD (chronic obstructive pulmonary disease) and respiratory failure and the interventions were to administer nebulizer treatment and oxygen as ordered.</p> <p>Review of Resident 321's Physician Order, dated 06/04/2024, reflected, Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML. 1 vial inhale orally three times a day for wheezing, sob (shortness of breath).</p> <p>Review of Resident 321's Physician Order, dated 06/18/2024, reflected, O2 AT 2-4 L/MIN CONTINUOUS PER via NC, every shift.</p> <p>(continued on next page)</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with Resident #321 on 06/18/2024 at 9:40 AM revealed that Resident #321 was on her bed resting. Resident #321 was on oxygen administration via nasal cannula. It was also noted that her mask for breathing treatment was on top of the side table. The breathing mask was not bagged. Resident #321 also had a portable oxygen tank at the back of her wheelchair. A nasal cannula was attached to the portable oxygen tank. The tubing of the nasal cannula was hanging on the backrest of the wheelchair with the prongs of the nasal cannula touching the seat of the wheelchair. The nasal cannula was not bagged. According to the resident, she had breathing treatment every morning. She said the nurse would put it on and would take it off.</p> <p>Observation and interview with CNA B on 06/19/2024 at 7:51 AM, CNA B stated the Resident #321's nasal cannula was hanging at the backrest of her wheelchair. She said the nasal cannula should not be hanging and touching the wheelchair because the wheelchair could be dirty. She said it should be bagged when the resident was not using it so the nasal cannula will not be contaminated. She said whoever assist the resident from transferring from wheelchair to bed should put the nasal cannula in a bag. CNA B went inside the room to get the nasal cannula but then stopped halfway and said she would call the nurse to replace the nasal cannula.</p> <p>Observation and interview with LVN A on 06/19/2024 at 8:38 AM, LVN A stated the breathing mask and the nasal cannula should not have been exposed nor touching anything because it could cause contamination and possible infection. LVN A said the breathing mask and the nasal cannula should be bagged when not in use. LVN A went to Resident #321's room and saw the nasal cannula at the back of the wheelchair. LVN A disconnected the nasal cannula from the portable oxygen and threw it on the trash can. She said she would get a new nasal cannula for Resident #321. She said she would also change Resident #321's breathing mask because it was placed on top of the table.</p> <p>Resident #322</p> <p>Review of Resident #322's Face Sheet dated 06/19/2024 reflected that resident was an [AGE] year-old female admitted on [DATE]. Relevant diagnoses included chronic obstructive pulmonary disease and chronic respiratory failure with hypoxia (long term condition where the lungs cannot get enough oxygen into the blood).</p> <p>Review of Resident #322's Care Plan on 06/19/2024 reflected no care plan for oxygen administration.</p> <p>Review of Resident #322's Physician Order on 06/19/2024 revealed no Physician Order for oxygen administration.</p> <p>Observation and interview with Resident #322 on 06/18/2024 at 9:48 AM revealed Resident #322 was on her bed, resting. It was noted that the resident had an oxygen concentrator at bedside. The oxygen concentrator was off. A nasal cannula was connected to the oxygen concentrator. The nasal cannula was hanging on top of the concentrator and was not bagged. Resident #322 stated she only use the oxygen if she needed it, like if she was having a hard time to breath. She said she had no recollection when was the last time she used her oxygen.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview with LVN A on 06/19/2024 at 8:41 AM, after coming out of Resident #321's room, LVN A then went to Resident #322's room and saw the nasal cannula hanging on the oxygen concentrator. LVN A disconnected the nasal cannula hanging on the oxygen concentrator and threw it on the trash can. She went to the supply room to get a new nasal cannula, a breathing mask, and plastic bags. LVN A stated she needed to change the nasal cannula and the breathing mask to prevent any respiratory infection.</p> <p>Observation and interview with LVN A on 06/20/2024 at 8:12 AM, LVN A stated Resident #322's order for oxygen was PRN. She logged on to her laptop to verify the order. LVN A said there was no order for oxygen. She said there should be an order for Resident #322's oxygen supplement so the staff would know that the resident had respiratory needs. She said the order for oxygen should be reflected on the resident's physician orders on the system. LVN A said since resident #322 as her resident, she was responsible in putting in the order for oxygen. She added she would put in the order and then started typing the order in the system.</p> <p>In an interview with the DON on 06/19/2024 at 11:18 AM, the DON stated the breathing mask and the nasal cannula should be bagged when not in use. The DON said it was the proper way to store the breathing mask and the nasal cannula. He said if those breathing apparatus were not bagged, exposed, or touching surfaces that were not clean, then oxygen administration could be compromised. The DON said it could also result to contamination and infection. He said the staff, including him, were responsible for monitoring that the nasal cannula and the breathing mask were bagged when not in use. He said that if a resident was using some oxygen, there should be an order specific for oxygen concentration to reflect the amount of oxygen, the duration, and the delivery device. He said the order is essential so the staff would be on the same page in caring for the respiratory need of the resident. He said without the order, the respiratory need of the resident will not be met. He said the expectation was for the breathing mask and the nasal cannula would be stored properly. He continued that another expectation was the staff to put the order on the system if there was an order for oxygen administration. The DON concluded that moving forward, he would educate the staff and would continually remind them to be diligent in making sure the procedures for respiratory care were followed.</p> <p>Record review of facility's policy, Oxygen Administration Nursing Manual - Nursing Care rev. 06/2020 revealed Purpose: To prevent or reverse hypoxemia and provide oxygen to the tissues . III. Infection Control . A. All oxygen tubing, humidifiers, masks, and cannulas . B. Oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use.</p> <p>Record review of facility's policy, Physician's Order, Telephone Orders and Recapitulation Process revised 11/2007 revealed, Policy: 1. Physician's orders shall be obtained prior to the initiation of any medication or treatment . Guidelines . 1 . order to the facility is necessary to show that the resident was admitted by a physician to this level of care . b.) Medication (Name, strength/dose, frequency, route of administration, diagnosis, PRN is to include specific reason).</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47743</p> <p>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 two (Resident #49 and Resident #89) of eight residents observed for infection control.</p> <p>The facility failed to ensure that CNA D changed his gloves and perform hand hygiene while providing incontinent care to Resident #49 and Resident #89.</p> <p>This failure could place the residents at risk of cross-contamination and development of infection.</p> <p>Findings included:</p> <p>Resident #49</p> <p>Review of Resident #49's Face Sheet, dated 06/19/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included hemiplegia (paralysis of one side of the body) and weakness.</p> <p>Review of Resident #49's Comprehensive MDS Assessment, dated 04/13/2024, reflected Resident #49 had a severe impairment in cognition with a BIMS score of 00. The Comprehensive MDS Assessment indicated Resident #49 was always incontinent for bowel and bladder.</p> <p>Review of Resident #49's Comprehensive Care Plan, dated 06/06/2024, reflected resident was incontinent of bowel and bladder related to impaired mobility and one of the interventions was to wash, rinse, and dry perineum (the space between the anus and the genitals).</p> <p>Observation on 06/18/2024 at 10:27 AM revealed CNA D was about to transfer Resident #49 to bed from the shower chair via mechanical lift. While waiting to be transferred, Resident #49 had a bowel movement and soiled the Hoyer sling. CNA D put on some gloves and continued to transfer the resident with the assistance of another staff. He did not wash his hands before putting on the gloves. After the transfer, CNA D rolled the resident towards the wall, rolled the soiled Hoyer sling and bed padding towards the center of the bed and tucked them under the resident. After tucking the soiled Hoyer sling and padding, CNA D took the new brief and placed it at the side of the resident. He did not change his gloves nor sanitized his hands before touching the new brief. CNA D then cleaned the resident's bottom. After cleaning the resident's bottom, CNA D took the new brief and put it under the resident's bottom and then rolled back the resident. He did not change his gloves nor sanitized his hands before putting the new brief on the resident's bottom. He then pulled the soiled Hoyer sling and padding, fixed the brief, and taped it on both sides. He took off his gloves but did not wash his hands after the incontinent care.</p> <p>Resident #89</p> <p>Review of Resident #89's Face Sheet, dated 06/19/2024, reflected resident was a [AGE] year-old male admitted on [DATE]. Relevant diagnoses included hemiplegia and weakness.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #89's Comprehensive MDS Assessment, dated 04/13/2024, reflected Resident #49 had a severe impairment in cognition with a BIMS score of 06. The Comprehensive MDS Assessment indicated Resident #89 was always incontinent for bowel and bladder.</p> <p>Review of Resident #89's Comprehensive Care Plan, dated 04/22/2024, reflected resident had an ADL self-care performance deficit related to CVA (cerebrovascular disease: stroke) and one of the interventions was for staff to assist with ADLs with needed assistance.</p> <p>Observation on 06/18/2024 at 10:59 AM revealed CNA D was about to transfer Resident #89 to his wheelchair. CNA D stated he would clean the resident first and change his clothes. CNA D put on his gloves. He did not wash his hands before putting on his gloves. CNA D unfastened the tape on both sides of the brief, pushed it between the legs of the resident, then rolled the resident to one side. He then proceeded to clean the resident's bottom. After cleaning the resident's bottom, CNA D pulled the soiled brief. He then changed his gloves but did not sanitize his hands. CNA D then took the new brief that was placed on the side of the resident's leg. The brief fell on the floor. CNA D picked it up and placed it on the resident's bottom. CNA D did not get another brief to replace the brief that fell on the floor. CNA D instructed and assisted the resident to roll back. CNA D then cleaned the front part of the resident, pulled the front part of the brief, and taped it on both sides. CNA D did not change his gloves nor sanitize his hands after cleaning the front part of the resident and before touching the new brief again. He then went to the resident's drawer to get new shorts. CNA D did not change his gloves nor sanitize his hands before touching the clean shorts. CNA D then took off the resident's hospital gown and put on the t-shirt that was prepared earlier and the shorts that was taken from the resident's drawer. CNA D took off his gloves and threw them in the trash can. He did not wash his hands after incontinent care.</p> <p>In an interview with CNA D on 06/18/2024 at 1:40 PM, CNA D stated he did not wash his hands before and after cleaning Resident #49 and Resident #89 but did put on new gloves before doing incontinent care. CNA D acknowledged that he did not change his gloves after cleaning the residents and before touching the new brief. He said he should had taken off his gloves, washed or sanitized his hands, and then put on new gloves after cleaning the resident and before getting the new brief. He said he should have replaced the brief that fell on the floor. He said not washing the hands before and after incontinent care, not changing the gloves before touching the new brief and clothes, not sanitizing the hands in between changing of gloves, and not replacing the brief that fell on the floor could cause cross contamination and infection. He said they do have in-services for infection control, handwashing, and incontinent care always.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the DON on 06/19/2024 at 11:18 AM, the DON stated he was made aware by the CNA involved about the infection control issue during incontinent care. The DON said every staff should wash their hands before and after every care. He said gloves should be changed and the hands should be sanitized after cleaning the resident's buttocks or the resident's front part before touching the any clean items. He said not washing the hands, not changing the gloves, and not sanitizing the hands in between changing of gloves could result to cross contamination and infection. The DON also added if the brief had fallen to the floor, it should not be used anymore for a simple reason that it was already dirty. The DON said the expectation was for the staff would remember to wash their hands and change their gloves when transitioning from a dirty area to a clean area, sanitize their hand when changing their gloves, and not to use items that had fallen to the floor. The DON said he already did a one-on-one in-service with CNA D but would do an infection control in-service for all the staff. He concluded that he would continually remind the staff to be attentive to the procedures for infection control and that he would personally monitor infection control.</p> <p>In an interview with LVN A on 06/20/2024 at 7:32 AM, LVN A stated the right procedure was to wash the hands and change the gloves after cleaning the bottom of the resident and before getting the new brief. She said the purpose of the method was to prevent cross contaminations and infections. She said microorganism could easily transfer if the gloves were not changed throughout incontinent care. LVN A added microorganisms could transfer from the soiled gloves to the new brief as well as to the clothes of the resident. She also said the brief should have been replaced because it already fell on the floor. She said the CNA should have not picked it up in the first place. She said she would remind the CNAs on her hall about the importance of washing hands before and after every care, changing gloves from dirty area to clean area, and sanitizing the hands in between changing of gloves.</p> <p>Record review of facility's policy, Hand Hygiene Infection Control Prevention and Control Program revealed Policy: This facility considers hand hygiene the primary means to prevent the spread of infections . b. Before and after direct contact with residents . h. 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 . m. After removing gloves . hand hygiene is the final step.</p> <p>Record review of facility's policy, Infection Control Prevention and Control Program revealed Policy: The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program . Goals: Promote individual resident's rights and well-being while trying to prevent and control the spread of infection.</p>		