STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676080	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates Arlington Inc	824 W Mayfield Rd Arlington, TX 76015

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 - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50445 Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of infection for 1 resident (Resident #1) of 3 observed for infection control. RN A failed to perform hand hygiene and change gloves during wound care for Resident #1. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #1's face sheet revealed she was a [AGE] year-old admitted to the facility on [DATE] with a primary admitting diagnosis of Traumatic Subdural Hemorrhage Without Loss of Consciousness (an abnormal collection of blood under the covering of the brain caused by trauma). Record review of Resident #1's Comprehensive MDS, dated [DATE], revealed a BIMS score of 03, indicating severe impairment in cognitive functioning. The Comprehensive MDS reflected Resident #1 required substantial/maximal assistance with eating, toileting hygiene, bathing, dressing, and repositioning. In an observation on 08/14/24 at 1:45 PM, wound care of Resident #1's coccyx revealed RN A washed her hands and put on gloves prior to the beginning of wound care. She removed the old dressing and cleaned the wound. She did not change her gloves, wash her hands, or use hand hygiene prior to applying the new dressing. After applying the new dressing and completing other tasks, she removed her gloves and washed her hands. In a review of records on 08/14/24 at 2:05 PM, a review of employee records for RN A reflected an infection control quiz signed by the employee and dated 07/22/24. (continued on next page)

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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a phone interview with RN A on 08/14/24 at 3:07 PM, she reported that handwashing should be completed before and after providing wound care to a resident. She reported that during today's (08/14/24) wound care for Resident #1 she washed her hands both before and after wound care. When asked if she washed her hands after removing the bandage and cleaning the wound (dirty), but before applying medication/new dressing (clean) she stated she did not. She stated it is understandable that this should be done and that once she finished clean activities, she should have removed her gloves and performed hand hygiene. She stated this helped prevent the reintroduction of the bacteria to the wound. In an interview with LVN B on 08/14/24 at 03:26 PM, he reported that he has worked at this facility about two years, first on double weekends, and more recently on the evening shift. He reported that staff should perform hand hygiene when they come into the residents' room and when they leave. In-between, he reported that the gloves would need to be changed and hands washed in-between when providing wound care and incontinence care. He reported that he had received infection control and handwashing in-service since being hired. He reported that failing to change gloves between clean and soiled parts of wound care could result in infection spreading. In an interview with CNA C on 08/14/24 at 03:50 PM, she reported that she had worked at this facility about seven years on both the evening and day shifts. She reported that when she entered a room to provide personal care, she washed her hands and put on gloves. She reported she removed her gloves after providing care and washed her hands. She reported that she changed her gloves and washed her hands during care when the gloves become soiled or when finishing cleaning the resident before starting clean activities. She stated she did this to prevent the spread of infection. She reported she had received infection prevention and handwashing teaching this past year. In an interview on 08/14/24 at 04:00 PM with ADON, she reported that she was the facility wound care nurse and had worked at the facility about 2.5 years. She reported that she expected staff to change their gloves and wash their hands as soon as they entered the room, after they completed their task, and if possible, in between. She stated they would need to sanitize their hands in-between care if for any reason they needed to change gloves before putting on another pair. She reported that during wound care staff were supposed to wash their hands, put on gloves, take off the old bandage, and change gloves and wash their hands before putting on the new bandage. She stated that infection could be a result of not doing this. She reported that staff had received handwashing and infection control prevention teaching at the beginning of this year (2024). In an interview on 08/14/24 at 04:27 PM, the DON reported that she was also the facility Infection Preventionist. She reported that staff should wash their hands before, after, and in between care. She stated that if their gloves were soiled, they should change them. For wound care, she reported that the hands should be washed before, after, and in-between before putting on a clean dressing. She reported all staff had received training for handwashing and infection control within the last month or so. She reported that staff who fail to wash their hands when going from dirty to clean activities could cause cross contamination and that this could cause the patient to get an infection. She reported that she, as the Infection Preventionist and the DON, was responsible for making sure that these things were being done. She reported she provided the staff with regular in-service training, that the staff had annual competencies, and that she watched staff to monitor for compliance with hand hygiene and infection control practices. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 08/14/24 at 05:00 PM, Administrator reported she had worked as the Interim Administrator since January (2024). She reported that she expected the employees to follow the facility's policies. She stated that when providing wound care, staff should not go from clean to dirty without hand hygiene and changing gloves. She stated that failing to do this could open the door for infection to occur. She reported the DON was responsible for ensuring the policy was being followed and providing in-services for the staff. Review of the facility policy titled, Handwashing/Hand Hygiene noted dated 2001 and revised August 2015, was reviewed. Number two of the policy states, All personnel shall follow the handwashing/hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. This policy states that an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water will be used before handling clean or soiled dressings, gauze pads, etc.; and before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after contact with blood or bodily fluids, and after handling used dressings, contaminated equipment, etc., after removing gloves.