STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676243	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remington Transitional Care of Richardson	1350 E Lookout Dr Richardson, TX 75082

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** 50222 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 to help prevent the development and transmission of communicable diseases and infections for two of three staff members (CNA A and CNA B) reviewed for infection control procedures. CNA A failed to perform hand hygiene after direct contact with residents while serving meals on the hallways, and CNA B failed to perform hand hygiene while delivering water to three residents. This failure could place residents at risk for healthcare associated cross contamination and infections. Findings included: Record review of Resident #246's annual MDS assessment, dated 04/30/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #246 had diagnoses which included: septicemia (infection that has spread to the bloodstream), urinary tract infection (within the last 30 days), hypertension (increased blood pressure), diabetes (increased sugar levels), and tracheostomy (tube surgically placed in trachea to maintain airway). Resident #246 was cognitively intact with a BIMS score of 15 and required assistance of one staff member for activities of daily living. Record review of Resident #196's annual MDS assessment, dated 05/06/24, revealed an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #196 had diagnoses which included: left hip osteoarthritis (degenerative joint disease that causes joint damage), coronary heart disease (disease of heart's major blood vessels), peripheral vascular disease (poor circulation to limbs), pulmonary fibrosis (lung tissue is damaged and scarred), and a personal history of malignant neoplasm of breast (history of breast cancer). Resident #196 as cognitively intact with a BIMS score of 15 and required assistance of one staff member for activities of daily living. Record review of Resident #85's annual MDS assessment, dated 04/11/24, revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #85 had diagnoses which included: Parkinson's disease (muscle and nerve disease), cellulitis of left finger (infection of left finger), hypertension (increased blood pressure), dysphagia (difficulty swallowing), and weakness. Resident #85 was cognitively intact with a BIMS score of 15 and required assistance of one staff member for activities of daily living. (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 - Some	Record review of Resident #98's annual MDS assessment, dated 05/05/24 (not completed), revealed a [AGE] year-old female who was admitted to the facility on [DATE]. The cognitive status in MDS had not been completed at the time of exit on 05/9/24. Record review of Resident #98's face sheet revealed diagnoses which included: enterocolitis due to clostridium difficile (bacterial infection of intestines), severe protein-calorie malnutrition (inadequate protein intake), acute systolic (congestive) heart failure (heart does not pump blood as well as it should), atrial fibrillation (irregular rhythm of the heart), and stage 4 pressure ulcer of sacral region (sore on area above the tailbone that extends to muscle, tendon, or bone). Resident #98 required assistance of staff for activities of daily living. Record review of Resident #248's annual MDS assessment, dated 05/03/24, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #248 had diagnoses which included: morbid (severe) obesity (overweight), anxiety (mood disorder), hypertension (increased blood pressure), hyperlipidemia (high levels of fat particles in the blood), and depression (mood disorder). Resident #248 as cognitively intact with a BIMS score of 15 and required assistance of one staff member for activities of daily living. Record review of Resident #97's annual MDS assessment, dated 05/08/24 (not completed), revealed a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #97 had diagnoses which included: urinary tract infection, renal insufficiency (kidney function is decreased), hypertension (high blood pressure), cerebrovascular accident (stroke), hypertension (increased blood pressure), hyperlipidemia (high levels of fat particles in the blood), and diabetes (increased sugar levels). Resident #97 required assistance of one staff member for activities of daily living. The cognitive status in MDS had not been completed at the time of exit on 5/9/24. Observation on 05/07/24 at 12:18 PM, revealed CNA A was pushing the meal cart down the hallway. CNA A was observed to enter Resident #246, #248, and #97's rooms touching each door handle and set up the residents' lunch trays, adjusted the overbed tables, unwrapped the utensils, and removed the tops off of the drinks for each resident. CNA A did not complete hand hygiene before going to the next resident. CNA A then returned to Resident #246's room and removed a pair of gloves from the box in the room. He then sat the gloves down and did not use them, repositioned the bedside table, and adjusted the items on the tray. CNA A then used utensils on the tray to feed Resident #246. After feeding the resident, CNA A left the room without washing hands or using hand sanitizer. Hand sanitizer was located on walls in hallways between rooms. Observation on 05/09/24 at 10:44 AM, revealed CNA B pushed the water cooler down the hall without gloves to the front of Resident #196's door, did not perform hand hygiene, touched the door handle and went inside Resident #196's room. Then CNA B went inside Resident #85's room and verbally offered water. CNA B then left that room and went inside Resident #98's room. CNA B did not perform hand hygiene before going to each resident's room. CNA B then used the white scoop on the side of the cooler and filled two cups. She took both cups into Resident #85's room, gave one cup to Resident #85 and adjusted the bedside table with bare hands. CNA B then took the other cup to Resident #98's room, placed the cup of water on the bedside table, and touched the bedside table. CNA B touched the door handle and left the room. CNA B did not perform hand hygiene during the observation. Hand sanitizer was located on walls in hallways between rooms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 05/08/24 at 12:37 PM, CNA A stated they should always wash their hands when removing gloves or use hand sanitizer. CNA A also stated when passing trays sometimes they use hand sanitizer, but if they are using gloves, they don't have time to perform hand hygiene between residents. An interview on 05/09/24 at 1:07 PM, the DON stated when passing trays CNAs were expected to complete hand hygiene between each resident. The DON also stated CNAs were expected to complete hand hygiene between residents when administering water. Record review of the facility's policy Infection Prevention and Control Program dated 5/13/23 revealed: Standard Precautions a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.