STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055869	A. BUILDING _____ B. WING _____	**07/16/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTRAL VALLEY POST ACUTE - MODESTO	**515 EAST ORANGEBURG AVENUE MODESTO, CA 95350**

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 implement infection control procedures for the prevention of Coronavirus (COVID-19, a contagious respiratory infection) transmission for five of five (Resident 5, 6, 7, 8, and 9) when Certified Nursing Assistants (CNA's) did not perform hand hygiene before and after handling dirty linen and in between resident care. These failures had the potential to result in the risk of transmitting COVID-19 to Residents and employees. Findings: During an observation on 6/19/20, at 10:25 a.m., in hallway three, CNA 1 pushed a cart. The cart was labeled dirty linen and trash. CNA 1 pushed the cart out the door at the end of hallway 3. CNA 1 did not wear gloves. During an observation on 6/19/20, at 10:26 a.m., outside in the facilities back lot, CNA 1 removed the trash bag, removed the dirty linen bag from the cart with bare hands, and placed them in containers. CNA 1 entered the facility and placed the cart against the wall in hallway 3. CNA 1 did not perform hand hygiene and did not disinfect the cart. During an observation on 6/19/20, at 10:28 a.m., CNA 1 did not perform hand hygiene before and after providing care to Resident 9. During an interview on 6/19/20, at 10:45 a.m., with CNA 4, CNA 4 stated, the facility had a process to clean the carts. CNA 4 stated, the carts were to be cleaned and wiped down with bleach wipes before the carts were brought back into the facility. During a concurrent observation and interview on 6/19/20, at 10:52 a.m., CNA 2 assisted Resident 8 into bed. CNA 2 assisted Resident 9 to sit up on the bedside. CNA 2 did not perform hand hygiene between Resident 8 and Resident 9. CNA 2 stated, she had worked in the facility for four days. CNA 2 stated, she had been a CNA for two years. CNA 2 stated, she had not been trained on hand hygiene. During an observation on 6/19/20, at 10:58 a.m., CNA 1 did not perform hand hygiene before and after providing care between Residence 5, Resident 6, Resident 7, and Resident 8. During an observation on 6/19/20, at 11:08 a.m., CNA 2 did not perform hand hygiene before and after providing care between Residence 5, Residence 6, Residence 7, and Residence 8. During an observation on 6/19/20, at 11:17 a.m., CNA 3 did not perform hand hygiene before and after providing care between Residence 5, Residence 6, Residence 7, and residence 8. During a review of the facility document titled Inservice Sign in sheet, Handwashing All Staff, dated 4/15/20, the Inservice Sign in sheet, Handwashing All Staff, did not indicate CNA 2's signature. During an interview on 7/13/20, at 9:45 a.m., with the Director of Nursing (DON), the DON stated, the carts were to be sanitized with bleach wipes before staff brought the carts back into the facility. During an interview on 7/13/20, at 9:46 a.m., with the DON, the DON stated, the expectation for CNA's was to be trained upon hire on hand hygiene. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene dated 2001, the P&P indicated, The facility considers hand hygiene the primary means to prevent the spread of infections .7. Use an alcohol-based hand rub containing at least 62% alcohol, or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .b. Before and after direct contact with residents . During a review of the facility's policy and procedure (P&P) titled, COVID-19 undated, the P&P indicated, .Emergency Operation Plan (EOP) .Support hand and respiratory hygiene, as well as cough etiquette by residents, visitors, and employees. Ensure employees clean their hands according to policies, washing with soap and water for 30 seconds, after contact with residents, after contact with contaminated surfaces or equipment .

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.