STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555827	A. BUILDING _____ B. WING _____	**07/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATHERTON PARK POST-ACUTE	**1275 CRANE STREET MENLO PARK, CA 94025**

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 -** Many	**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 program designed to provide a safe and sanitary environment to help prevent the development and potential transmission of communicable infections. Failure to use personal protective equipment (PPE) in accordance with recommendations may contribute to the spread of infections. Additionally, the use of a single mop head in multiple rooms could also contribute to the spread of infections. Findings include: 1. On 07/21/2020 at approximately 3:30PM Housekeeping Staff 15 was requested to explain and demonstrate the process for cleaning resident rooms. Staff 15 verbalized the entire cleaning process; he explained what cleaning agents he used and articulated the length of time the cleaning agents should remain wet for the disinfectants/sanitizers to be effective. Lastly, he explained how he would dust mop and mop the floor. Housekeeping Supervisor Staff 16 was present during the entire observation and concurrent interview. Staff 15's housekeeping cart was observed and it contained only one wet mop that was sitting in a bucket of solution. When questioned on how frequently he changed the mop water he stated the water was changed every 3 hours. During further interview, Staff 15 revealed if the floor in the resident rooms was not that dirty he would use the same mop head to mop at least two more resident rooms. Staff 16, the Housekeeping Supervisor, reiterated the questions in Spanish and validated the responses received from Staff 15. The potential for the spread of infection was acknowledged. On that same date the facility policy regarding moping was requested however it was not received. On 7/22/2020 near 09:00AM Housekeeping Staff 12 was interviewed regarding her mopping practices prior to 7/22/2020. She reported prior to 7/22/2020 she changed the mop head every three rooms and changed the mop water every hour. She further explained as of 7/22/2020 she used one mop head per room and did not reinsert the mop head into the bucket of mop solution. On 07/22/2020 near 10:00AM Housekeeping Staff 14 was interviewed regarding her mopping practices prior to 7/22/2020. She reported the mop head was changed every three resident rooms or every room depending on how dirty the room was. She continued to explain that the mop water, prior to 7/22/2020, was changed every three rooms but if it was too dirty it would be changed every room. On 7/22/2020 the Procedures for Cleaning Floors Housekeeping Department was received and reviewed. The procedure had been updated as of 07/21/2020. The Mopping Procedure indicates: -Mop in a systematic manner, proceeding from area farthest from the exit and working towards the exit. -Leave bathroom for last. -Change mop heads after EVERY room and bucket of cleaning solution change it every three rooms, every hour or if found floor dirtier change water immediately. 2. Observations of several staff's use of PPE and hand hygiene occurred throughout the survey. On 7/22/2020 near 5:00PM, specific observations of PPE use were completed with the Director of Nurses (DON) and the Infection Control (IC) Nurse. On that date, Licensed Nurse Staff 1(Staff 1) was observed to come out of a Person Under Investigation (PUI) room (#335), he complete hand hygiene and remove his N95 mask. For a period of 3-5 minutes Staff 1 completed several other task before donning a regular face mask and continued to provide care to other residents. The DON and the IC Nurse witnessed the same observation and later acknowledged the observed nurse could have put on a mask shortly after exiting the PUI resident room. Within the same hall near 5:15PM Certified Nursing Assistant 2 was observed donning PPE as she was delivering the supper tray to a PUI resident in room [ROOM NUMBER]. As she was exiting the room she used hand sanitizer, removed her N95 facemask by grasping the mask from underneath the chin and raising the mask forward, and up toward the crown of her head. The N95 was stored in a brown bag and a regular facemask was donned; she continued to provide care to other residents. The IC nurse acknowledged the inappropriate doffing and validated the mask should have been doffed by grasping the elastics at the bottom of the head then the elastic at the top of the head rather than grabbing the mask from front and chin. The IC nurse indicated that staff member would be inserviced on donning and doffing. The facility policy regarding Source Control was reviewed and it states: Proper facemask will be worn by staff unless the supply is depleted and a need to use facility backup supply of cloth facemask is required. The facility Procedure for Person Under Investigation (PUI) indicates 1. Patient can become a PUI if patient exhibits new unexplained, fever, sore throat (new cough & fever) and shortness of breath. Currently according to CDC (Centers for Disease Control) people with these symptoms may have COVID-19.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE