STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055846	A. BUILDING _____ B. WING _____	08/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE TERRACES AT SAN JOAQUIN GARDENS VILLAGE	5551 N. FRESNO ST FRESNO, CA 93710

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** Based on observation, interview, and record review, the facility failed to implement and maintain a safe environment with an effective infection prevention and control program for the prevention of a [MEDICAL CONDITION] (COVID-19- a contagious serious respiratory infection transmitted from person to person) outbreak when: 1. One Certified Nursing Assistant (CNA) 1 did not wear gloves when handling soiled linens and did not sanitize her hands after handling trash. 2. All doors to the residents' rooms in the Person Under Investigation/ Observation Unit (PUI/OU- a unit that housed residents who may have had close contact with confirmed COVID-19 and/or may have been exposed to COVID 19) were kept open. 3. The Physical Therapist/Rehab Director (PT/RD- a professional that helps individuals develop, maintain and restore maximum body movement and physical function) did not follow the facility's infection control protocol to dispose of soiled gown as near as possible to the exit of the resident's room. These failures could cause residents and staff to acquire COVID 19 which would place the resident's health and safety at risk for harm. Findings: 1. During a concurrent observation and interview with CNA 1 on 8/26/20 at 2:05 p.m., in the soiled linen room, CNA 1 took a barrel into the soiled linen room. The barrel had two compartments; one compartment was labeled Trash and the other compartment was labeled Soiled Linen. CNA 1 unzipped the Trash compartment, took out the plastic bag full of trash and threw it into the large trash bin. CNA 1 then unzipped the Soiled Linen compartment, took out the plastic bag full of soiled linens and placed it in the large soiled linen bin. CNA 1 did not wear gloves when she disposed the trash and soiled linens. She did not wash her hands nor perform hand hygiene (cleaning one's hands with soap and water or an alcohol- based hand sanitizer to reduce the spread of germs) after she had handled/disposed of the trash and soiled linens. CNA 1 stated she should have donned (put on) gloves when handling and disposing of the trash and should have washed her hands before she disposed of trash and soiled linens, and should have washed or sanitized her hands afterwards. CNA 1 stated she was trained to wear gloves and to sanitize or wash her hands when handling potentially contaminated items. CNA 1 stated, it was important to wear gloves and sanitize hands after disposing of the trash and soiled linens to prevent cross contamination between residents and staff. There were no hand sanitizers or hand washing station in /or near the soiled linen room. During an interview with CNA 2 on 8/26/20 at 3:09 p.m., CNA 2 stated he had been trained to wear gloves when disposing of soiled linen and trash. He stated, if he did not wear gloves or wash his hands after disposing of trash, there was an increased risk of cross contamination. During an interview with Licensed Vocational Nurse (LVN) 1 on 8/28/20 at 11:03 a.m., LVN 1 stated the reason for sanitizing/washing hands was to stop the spread of infection. She stated she had been trained to wear gloves when there was potential bodily fluid exposure or when disposing of contaminated linen. LVN 1 stated if she did not wear gloves or wash her hands before and after disposing of trash and/or soiled linen, there was an increased risk for cross contamination and spread of infection. During a telephone interview with CNA 5 on 8/28/20 at 11:28 a.m., CNA 5 stated the main goal for hand-washing/sanitizing was to stop the spread of infection between residents and staff. CNA 5 stated she would always wear gloves and sanitize hand when handling soiled linen or trash to protect residents. CNA 5 stated she had been trained to put on gloves before disposing of soiled linen and to wash or sanitize hands when done handling soiled linen. During a telephone interview with the Infection Preventionist (IP) on 8/28/20, at 12:22 p.m., the IP stated she had provided training to staff on hand hygiene, use of gloves and how to dispose of dirty linen and trash. The IP stated CNA 1 had been trained on how to dispose of soiled linen and trash according to the Center for Disease Control (CDC) and Prevention Guidelines. She stated CNA 1 should have worn gloves before handling soiled linen and trash, and should have washed or sanitized her hands when done. During an interview with the Director of Nursing (DON) on 8/28/20 at 1:05 p.m., the DON stated CNA 1 should have performed hand hygiene and wore gloves when handling soiled linen and trash. DON stated it was very important that the staff performed hand hygiene to decrease the risk of cross contamination and spread of infections. During a professional reference review, retrieved on 9/7/2020, from https://www.cdc.gov/oralhealth/infectioncontrol/faqs/hand-hygiene.html, titled, Hand Hygiene .What is hand hygiene undated, indicated, Hand hygiene is a way of cleaning one's hands that substantially reduces potential pathogens (harmful microorganisms) on the hands. Hand hygiene is considered a primary measure for reducing the risk of transmitting infection among patients and health care personnel. Hand hygiene procedures include the use of alcohol-based hand rubs (containing 60%-95% alcohol) and hand washing with soap and water . During a professional reference review, retrieved on 9/7/2020, from https://www.who.int/gpsc/5may/Hand_Hygiene_Why_How_and_When_Brochure.pdf?ua=1, titled, Hand Hygiene: Why, How and When undated, indicated, .Why? . Thousands of people die every day around the world from infections acquired while receiving health care. Hands are the main pathways of germ transmission during health care. Hand hygiene is therefore the most important measure to avoid the transmission of harmful germs and prevent health care-associated infections .When .After body fluid exposure risk .Why? To protect you from infection with patient's harmful germs and to protect the health-care environment from germ spread When? .Clean your hands as soon as the task involving an exposure risk to body fluids has ended . after cleaning any contaminated surface and soiled material (soiled bed linen) .Examination gloves indicated in clinical situations .Potential for touching blood, body fluids, secretions, excretions and items visibly soiled by body fluids . Indirect patient exposure: Emptying emesis basins; handling/cleaning instruments; handling waste; cleaning up spills of body fluids . During a professional reference review, retrieved on 9/7/2020, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 7/15/20, indicated, .Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection .Hand Hygiene . HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves .HCP should perform hand hygiene by using ABHS with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS. Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location During a review of facility's policy and procedure titled Surveillance for Infection dated 8/2014, indicated, .Hand washing is the most important element in preventing the spread of viruses . During a review of facility's policy and procedure titled Handwashing/Hand Hygiene dated 8/2015, indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . 2. During a concurrent observation of the facility's PUI/OU and interview with the Administrator (ADM) and DON on 8/25/20, at 3:22 p.m., all bedroom doors the PUI/OU were opened. ADM stated she was not aware that the doors to residents' room in the PUI/OU need to be closed. ADM stated she thought the doors had to be closed only in the Red Zone (designated rooms for confirmed COVID-19 positive residents). During a telephone interview with LVN 1 on 8/28/20 at 11:03 a.m., LVN 1 stated, residents in the PUI/OU were recently admitted or readmitted to the facility. LVN 1 stated these residents were suspected to have been exposed to COVID-19. LVN 1 stated these residents were treated as potentially

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) having COVID-19. LVN stated she was not aware that the doors to all the rooms in the PUI/OU unit should be closed. LVN was not able to verbalize the reason why the door needed to be closed in PUI/OU. During a telephone interview with the Infection Preventionist (IP) on 8/28/20 at 12:22 p.m., the IP stated she was not aware of CDC guidelines to close the doors of all residents' rooms who were suspected to have COVID or may have had been exposed to COVID-19. The IP stated she thought only the bedroom doors in the Red Zone had to be closed. During a telephone interview with DON, on 8/28/20, at 1:10p.m., the DON stated she was not aware the doors to residents' rooms in the PUI/OU needed to be closed. She stated the doors to the residents' rooms would be closed only in the Red Zone. The DON stated, The information regarding closing doors of the rooms in PUI/OU are new to me. During a professional reference review, retrieved on 9/7/2020, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 7/15/20 indicated, . Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection . If admitted , place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection in a single-person room with the door closed . 3. During an observation on 8/25/20 at 3:45 p.m., in the PUI/OU, the PT/RD went inside a resident's room, put on a gown, and after approximately ten minutes, PT took off her gown, held it in her hand and came out of the resident's room. There was no soiled linen barrel available by resident's room. The PT/RD carried the used gown in her hands, walked across the hallway, and disposed the gown in another room where asoiled linen barrel was located. During an interview with the PT/RD on 8/25/20 at 4:04 p.m., the PT/RD stated, the reason the residents were placed in the PUI/OU was that they might have been exposed to a person who was COVID 19 positive. She stated she should have not carried the soiled gown across the hallway in her hands. PT/RD stated she should have disposed of the soiled gown in or right outside the redident's room. PT/RD stated she was trained by IP on how to disposed of the soiled laundry according to current CDC guidelines, and the facility's infection control policy, which indicated to discard used linen in or near the resident's room. During a review of facility's mitigation plan, dated 6/30/20 indicated, .Trash bins will be positioned as near as possible to the exit inside a resident room to make it easy for staff to discard PPE after removal, prior to exiting the room . During a professional reference review, retrieved on 9/7/2020, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 7/15/20, indicated, . Gowns: put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area .