STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055185	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN CITY HEALTHCARE CENTER	1310 WEST GRANGER 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement and maintain an effective infection prevention and control program for the prevention of [MEDICAL CONDITION] (COVID-19 ([DIAGNOSES REDACTED]-CoV -2) - a contagious serious respiratory infection transmitted from person to person) outbreak when: 1. One of three sampled Certified Nursing Assistant (CNA) 3, did not perform hand hygiene after doffing (take off) and donning (put on) used personal protective equipment (PPE- i.e. mask and face shield, equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses). 2. Two of three sampled Housekeeping Staff (HK) 2 and HK 3, did not follow disinfection solution manufacture recommendations wet time (contact time, also known as the wet time, is the time that the disinfectant needs to stay wet on a surface in order to ensure efficacy) to ensure environmental cleaning and disinfection (process of destroying bacteria) procedures were followed consistently and correctly. 3. One of three sampled Housekeeping Staff HK 2, did not label, time or date the disinfection spray bottle containing premixed disinfection solution (a chemical liquid that destroys bacteria). These failures had the potential to spread pathogens such as the [DIAGNOSES REDACTED]-CoV-2 virus which causes COVID-19 illness or other communicable diseases to residents and staff. Findings 1. During an observation on 8/26/20, at 10:50 a.m., in a used PPE doffing room, CNA 3 walked into the PPE doffing room and removed his mask and face shield. CNA 3 walked out of the used PPE doffing room without performing hand hygiene. CNA 3 walked out of the facility and approximately three minutes later he walked back into the used doffing PPE room and put his used mask and face shield back on without performing hand hygiene. CNA 3, stated, I forgot my wallet. CNA 3 was going leaving for his meal break. CNA 3 then walked down the hallways and into the nurses' station opening drawers and touching work surfaces without performing hand hygiene. During an interview on 8/26/20, at 11:51 a.m., with CNA 3, CNA 3 validated that he had not performed hand hygiene after he removed his used PPE and he should have. CNA 3 stated he should have washed his hands after taking off his used and possibly contaminated PPE and after putting on his used and possibly contaminated PPE. During an interview on 8/26/20, at 2:46 p.m., with the Director of Nursing (DON), the DON stated, CNA 3 should have performed hand hygiene after taking off his used and possible contaminated PPE and after putting on his used PPE. During a review of the facility's policy and procedure (P&P) titled, Hand washing/Hand Hygiene, dated 8/2015, indicated, This facility considers hand hygiene the primary means to prevent the spread of infections (staff must) Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water . for the following situations: a. before and after coming on duty . 8. Hand hygiene is the final step after removing and disposing of PPE . 2. During a concurrent observation and interview on 8/26/20, at 11:09 a.m., with HK 2, out in the hallway, HK 2 was observed cleaning and disinfecting resident room frequently touched surfaces with a liquid disinfectant solution. HK 2 took an unlabeled bottle of disinfectant spray and sprayed the disinfection solution on the light switch, nightstands and the resident overbed tables. HK 2 stated she would allow the disinfectant spray to remain wet on surfaces for only two minutes and then make sure it was dry. HK 2 stated the facility disinfection process was to spray (brand name) cleaning solution on frequently touched surfaces and allow the surfaces to remain wet for only two minutes then dry. HK 2 stated the previously disinfection process required HK staff to allow disinfection solution to remain wet on surfaces for a minimum of ten minutes but in the past week the facility disinfection process had changed to only keep frequently touched surfaces wet for two minutes. HK 2 read the disinfection solution manufacture instructions, indication, .Wet time .10 minutes . and stated she did not keep surfaces wet for 10 minutes. During an interview on 8/26/20, at 2:52 p.m., with Housekeeping Supervisor (HKS), the HKS stated, according to (brand name) cleaning and disinfectant product efficacy data for [DIAGNOSES REDACTED] ((a contagious serious respiratory infection transmitted from person to person) Coronavirus2 caused from COVID 19) contact wet time was ten minutes. HKS stated, housekeeping staff are expected to know and leave the disinfection solution on surfaces for the correct contact time. During a concurrent observation and interview on 8/26/20, at 3:35 p.m., with HK 3, in the hallway, HK 3 was observed cleaning residents' room with (brand name) disinfectant. HK 3 maintained the disinfection solution on frequently touched surfaces for two minutes. HK 3 stated after spraying (brand name) cleaning product she would keep surfaces wet for only two minutes. HK 3 stated the HKS informed her that disinfection wet time had changed from ten minutes previously to now only two minutes. During an interview on 8/26/20, at 4:05 p.m., with the Infection Preventionist (IP), the IP read the (brand name) cleaning and disinfection solutions and stated, housekeepers should have followed the manufactures recommendation to maintain surfaces wet for a minimum of 10 minutes per the manufacture recommend contact time. The IP stated if housekeepers are not following manufactory recommendation, the environmental surfaces would not be effectively disinfected. During a review of the (brand name) Disinfectant manufacturer Product information, undated, indicated, Description .effective against a broad spectrum of bacteria. It is viricidal (destroys viruses) .Directions Apply this product with a cloth, mop or mechanical spray device. When applied with a mechanical spray device, surfaces must be sprayed until thoroughly wetted . with a 10-minute contact time (the amount of time the surface must remain visibly wet in order to kill pathogens (germs that can cause disease)) and found to be effective against the following viruses on hard non porous environmental surfaces . [MEDICAL CONDITION] (liver infection) virus, [MEDICAL CONDITION] (liver infection) Influenza A (H1N1- [MEDICAL CONDITION] disease) Product information also indicated [DIAGNOSES REDACTED] related Coronavirus2 cause of COVID-19, 4 minutes . 3. During a concurrent observation and interview on 8/26/20, at 11:09 a.m., with HK 2, in the hallway, HK 2 was observed cleaning and disinfecting residents' room surfaces with unlabeled disinfectant spray bottle. HK 2 validated the disinfectant spray bottle did not have a label, date or time the disinfection solution was prepared. HK 2 stated the disinfectant spray bottle should have been labeled with a label that indicated what type of disinfectant solution was in the bottle and the time and date the solution was prepared. HK 2 stated the spray bottle should have been labeled because the disinfectant solution was effective against pathogens for only 24 hours. After the 24 hours the solution would be ineffective and would need to be discarded. HK 2 stated she forgot to label the spray bottle and she should have taken the times to label, time and date the disinfection solution bottle. HK 2 stated the risk on using the (brand name) disinfection solution past the 24-hour time frame, would be that surfaces would not get disinfected and could cause spread of infection to residents and staff. During an interview on 8/26/20, at 2:52 p.m., with the HKS, the HKS stated disinfectant container should have been labeled with information that included the type of disinfectant being used, time and date the solution was prepared. The HKS stated the solution was only good for 24 hours. HKS stated the disinfection solution loses its potency after the 24 hours period. During a review of the facility document titled, (brand name) Disinfectant Product information, undated, indicated, Directions . label for ready to use .effective against a broad spectrum (antibiotic that acts on the two major bacterial groups) of bacteria .mechanical spray device Prepare a fresh solution at least daily (24 hours) .

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.