STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056376	A. BUILDING _____ B. WING _____	10/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
A GRACE SUB ACUTE & SKILLED CARE	1250 S. WINCHESTER BOULEVARD SAN JOSE, CA 95128

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 document review, the facility failed to ensure staff were implementing infection prevention practices when: 1. Two of two housekeeping (HK) staff did not follow proper on control practices when cleaning resident rooms, 2. A licensed nurse did not perform hand hygiene after removing gloves, 3. A medical assistant when attempting to perform a Coronavirus disease 2019 (COVID-19, [MEDICAL CONDITION] identified as the cause of a world-wide outbreak of respiratory illness) test for a resident did not properly don (put on) a cover gown, 4. Mandatory staff education was not provided to sufficient number of staff members, 5. One of two licensed nurses did not know the proper order of donning and doffing (taking off) personal protective equipment (PPE, specialized clothing or other wearable gear that helps prevent the spread of infection to others), 6. And, there was a lack of monitoring for the use of (high-efficiency particulate air) HEPA filters, a machine with a filter that reduces particles in the air. These failures had the potential to spread infection to residents and staff. Findings: 1. On 10/22/2020 at 10:30 a.m., HK A was observed cleaning room [ROOM NUMBER] occupied by three residents. After spraying a cloth towel with a disinfectant, HK A wiped the top surface bedside table of the C bed (bed closest to the window), wiped the metal base of the same table that was approximately two to three inches from the floor and towel touched the floor. HK A used the same towel to clean the bedside table of the B bed (middle). The HK A did not clean the light switch and door knob of the room before proceeding to clean another room. On 10/22/2020 at 11 a.m., HK B was observed cleaning room [ROOM NUMBER] occupied by two residents. HK B placed two plastic bags both containing towels next to each other and they were on top of a garbage barrel. During room cleaning, HK B took towels from one plastic bag and after using them to clean the room, placed the dirty towels into the other plastic bag. room [ROOM NUMBER] had a privacy curtain that was stained with a brown discoloration at the chest level of HK B. While cleaning room [ROOM NUMBER], HK B moved the curtain from the A bed (room close to the door) forward and backsword several times without changing gloves. Towards the end of room cleaning, HK B who was not wearing a cover gown walked into and her torso was in contact with the stain of the privacy curtain. During an interview on 10/22/2020 at 11:17 a.m., the HK supervisor who also observed HK B cleaning room [ROOM NUMBER] stated the plastic bags containing cleaning towels should not be placed together and on top of the garbage container and acknowledged the infection control concern of HK B in contact with the soiled privacy curtain. During an interview on 10/22/2020 at 5:50 p.m., the director of nurses (DON) acknowledged a towel should not be used to clean items belonging to two residents and cleaning towels when touching the floor was considered dirty. Review of the Cleaning and Disinfection Residents' Rooms policy, revised August 2013, directed staff to clean personal items such as lights with disinfectant solution at least twice daily. The policy did not have procedures indicating the step by step procedure of room cleaning i.e. what to clean first, room or bathroom, mattress or bedrails, when cleaning items such as towels were considered dirty, when to change gloves, and when to launder or clean privacy curtains. 2. During an observation on 10/22/2020 at 10:25 a.m., licensed vocational nurse (LVN) C entered a room with gloved hands, spoke to the resident, touched his blanket and siderails, removed gloves and left the room. The LVN C returned to the medication cart in the hallway and donned clean gloves without performing hand hygiene. During an interview at 10:26 a.m., LVN C stated she should have performed hand hygiene after removing her gloves. The Handwashing/Hand Hygiene policy, dated August 2015, indicated hand hygiene is the final step after removing and disposing of personal protective equipment (gloves) and to perform hand hygiene before applying non-sterile gloves. 3. During an observation on 10/22/2020 at 11:20 a.m., medical assistant (MA) D was in a hallway gathering equipment to perform a COVID test. The MA entered room [ROOM NUMBER] and her cover gown was not tied to her neck and back. The resident refused to be tested . During an interview on 10/22/2020 at 11:22 the MA stated she should have tied her cover gown at the back. Review of the undated SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE) policy indicated when donning a gown to fasten at the back of neck and waist. 4. During an interview on 10/22/2020 at 9:20 a.m., the administrator (ADM) stated the facility had approximately 175 staff. Review of the In-Service Training Class Lesson Plan, dated 2/7/2020, addressed the Novel Coronavirus infection and its symptoms, what to do if staff gets exposed to COVID-19 and and how to put on the new PPE. Fifty four staff members had attended the mandatory in-service. Review of the In-Service Training Class Lesson Plan, dated 3/12/2020, addressed measures to prevent spread of COVID-19, provided information from the California Department of Public Health guidelines, sick leave policy, health screening for staff and visitors and limiting visitations. Twenty eight staff members had attended the Mandatory in-service. Review of the In-Service Training Class Lesson Plan, dated 6//2020, addressed there was positive COVID-19 residents (residents infected with COVID-19) in the facility, educated staff providing care to COVID-19 residents to stay in a red designated area (area where COVID-19 residents resided) and to keep non-COVID residents out of the area. Thirty four staff members had signed indicating they had attended the Mandatory in-service. Review of the In-Service Training Class Lesson Plan, dated 3/12/2020, provided an update on COVID-19, special assignment of volunteers, reminder of PPE use and isolation requirements and the importance of handwashing. Forty three staff members had attended the Mandatory in-service. Review of the In-Service Training Class Lesson Plan, dated 6/2/2020, provided information about handling biohazard (biological agent or condition such as [MEDICAL CONDITION] that is hazard to humans or the environment) materials and mitigation plan (plan to control and manage COVID-19 infection). Fifty one staff members had attended the Mandatory in-service. Review of the In-Service Training Class Lesson Plan, dated 6/5/2020, informed new residents had tested COVID-19 positive, educated staff to not to cross the Red Zone, identified specific staff who were to render care for residents in the Red Zone, reminded to watch residents to not cross to the Red Zone, and informed about the required regular testing for COVID-19. Thirty four staff members had attended the Mandatory in-service. During an interview on 10/22/2020 at 3:15 p.m., the director of staff development who provided the in-service records stated she had been in-servicing day shift (7 a.m. to 3 p.m.) and evening shift (3 p.m. to 11 p.m.) staff and the ADM had been in-servicing the night shift staff (11 p.m. to 7 a.m.). The DSD did not offer any explanation as to why the majority of staff were not in-serviced. 5. During an interview on 10/22/2020 at 5 p.m., LVN E stated she had been providing care to residents that required full PPE (gown, mask, gloves, face shield, shoe cover and hair cover). LVN E said when donning PPE, she would gown, put on gloves, mask, and face shield. When taking off PPE, she would remove gown, gloves, and mask. Providing hand hygiene was not mentioned after doffing. Review of the undated SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE) policy indicated the order of donning PPE was gown, mask or respirator, goggles or face shield and gloves. The doffing sequence of PPE was to remove gown and gloves, goggles or face shield, mask or respirator and to wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE. 6. During an interview on 10/ 20 at 10:15 a.m., the ADM stated the facility has had a history of [REDACTED]. The ADM also said the facility so far had acquired 10 of them. During a tour of the facility on 10/22/2020 at 10:25 a.m. in the subacute unit (residents on ventilators or oxygen) the DON had asked at least two licensed nurses where the HEPA filters located. room [ROOM NUMBER] had a HEPA filter in the middle bed but the machine was turned off. During an interview on 10/22/2020 at 5:50 p.m., the ADM did not provide documentation indicating where the HEPA filters where placed, if they were monitored for use and function and how many more were needed.

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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