STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555118	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR POST-ACUTE HEALTHCARE CENTER OF MODESTO	2030 EVERGREEN 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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow infection control and prevention procedures for the prevention of Coronavirus (a highly contagious respiratory infection known as COVID-19) transmission when: 1. Residents 1, 2 and 3's shared isolation room had a shelf outside the room that had a visibly used, contaminated isolation gown laying on top of clean Personal Protective Equipment (PPE) supplies. The room occupied by Residents 1, 2 and 3 was designated as an isolation room due to the possible Covid positive status of the residents. 2. Residents 1, 2 and 3's shared isolation room had an uncovered trash bin exposing trash and other contaminated items against facility policy and procedure. 3. Center for Disease Control (CDC) recommendations for person under investigation (PUI) for COVID-19 virus were not followed when bedroom door for PUI Residents 1, 2 and 3's was left opened. 4. PUI rooms [ROOM NUMBERS] had visibly used, contaminated, unlabeled isolation gowns hanging freely over the front door of resident closet and on top of resident cabinet drawer instead of their designated hooks. These practices had the potential to place residents and staff at risk for the spread and transmission of COVID-19 virus. Findings: During an observation on 7/8/20 at 12:50 p.m., of Residents 1, 2 and 3 isolation room, a sign indicating, Droplet/contact infection control precaution was posted outside the room. Next to the front door, a shelf was stocked with clean PPE and laying on top of the clean PPE, was a viably used, contaminated isolation gown. During a concurrent observation and interview with Infection Preventionist (IP), on 7/8/2020, at 1:04 p.m., in the corridor near Residents 1, 2 and 3's room, the IP stated Resident 1, 2 and 3 were isolated because the residents were considered PUIs for COVID-19 virus infection. The IP confirmed that a reusable, contaminated isolation gown was laying on top of the clean PPE supplies on the shelf. He stated laying the contaminated isolation gown on top of the clean PPE was not an appropriate place to store the contaminated isolation gown. The IP stated placing the contaminated isolation gown on top of the clean PPE could cause cross contamination and cause the spread of COVID -19 infection to other residents and staff. The IP stated staff should have hung the contaminated isolation gown on a hook on the wall. The IP looked for the hook that he stated should have been placed on the wall and stated, I can't see any hooks on the wall. The IP stated the staff was educated to use one gown per resident per shift (8 hours) and at the end of the eight hour shift the contaminated gown should have been discarded. During a concurrent observation and interview on 7/8/2020, at 1:30 p.m., in the yellow zone with Licensed Vocational Nurse 1 (LVN 1), the LVN 1 stated used and reusable gowns should be hanged on the hooks by the wall and not placed on clean PPE. LVN 1 stated the clean PPE would not longer remain clean and would have to be discarded or washed if the PPE was washable. During a telephone interview with Licensed Vocational Nurse (LVN 2), on 7/9/20, at 12:17 p.m., LVN 2 stated she was the nurse assigned to care for Residents 1, 2 and 3 on 7/8/20. LVN 2 stated disposable isolation gowns should be thrown after each use and reusable (washable) isolation gowns should be hung on a hook after use and sent to the laundry for washing at the end of the eight-hour shift. LVN 2 stated, I am not sure if there were hooks installed on the wall yesterday (7/8/20). During a telephone interview with Certified Nurse Assistant (CNA 2), on 7/9/20, at 1:05 p.m., CNA 2 stated she had been assigned to provide direct care to Resident 1, 2 and 3 on 7/8/20. CNA 2 stated she left the used contaminated isolation gown on top of the clean PPE supplies stored on the shelf by the door because, There were no hooks inside the room and it was the only place to put the gown. CNA 2 stated laying her contaminated isolation gown was not a good infection control practice because the contaminated isolation gown contaminated the clean PPE supplies. CNA 2 stated placing the contaminated gown on top of clean PPE could cause the spread of COVID-19 virus. CNA 2 stated, I should have thrown the gown away if no hooks were available. 2. During a concurrent observation and interview with the IP, on 7/8/2020, at 1:04 p.m., in front of Residents 1, 2 and 3's isolation room, an uncovered trash bin was observed inside the room. The IP stated the trash bin was not covered and it should have been covered to reduce cross contamination and reduce the spread of infection. During a telephone interview LVN 2 on 7/9/2020, at 12:17 a.m., LVN 2 stated she was the assigned nurse for Residents 1, 2 and 3 on 7/8/20. LVN 2 stated the trash bin inside Residents 1, 2 and 3's isolation room did not have a lid to keep it covered. She stated that a covered trash bin should have been placed in the isolation room to prevent the spread of infection. During a telephone interview with CNA 2, on 7/9/2020, at 1:05 p.m., CNA 2 stated she had been assigned to provide care for Residents 1, 2 and 3 on 7/8/20. CNA 2 stated the trash bin in Residents 1, 2 and 3 did not have a lid to cover the trash. CNA 2 stated the uncovered trash bin had the potential to cause cross contamination and spread of COVID -19 infection. 3. During a concurrent observation and interview on 7/8/2020, at 1:04 p.m., in the green zone of Residents 1, 2 and 3 with Infection Preventionist (IP), IP stated Resident 1, 2 and 3 were considered as person under investigation (PUI) for COVID-19. IP stated isolation room should be close to reduce exposure of other residents and staff. During a telephone interview on 7/9/2020, at 12:17 p.m., with Licensed Vocational Nurse (LVN 2), she stated she was assigned to Residents 1, 2 and 3 in isolation room. She stated she closed the door after giving medication yesterday but was not sure if the other staff who takes care of the residents might have forgotten to close the door. LVN 2 stated isolation room door should be closed always after use to prevent the spread of infections. During a telephone interview on 7/9/2020, at 1:05 p.m., with Certified Nurse Assistant (CNA), she stated she was assigned to Residents 1, 2 and 3 on 7/8/20. CNA stated Residents 1, 2 and 3 were considered as person under investigation (PUI) for COVID-19. CAN 2 stated she was not certain if the doors needed to remain shut. CAN 2 stated she should have asked licensed nurses if room doors are needed to be closed or left open. 4. During a concurrent observation and interview with Certified Nursing Assistant (CNA 5), on 7/16/20, at 2:25 p.m., in yellow zone in room [ROOM NUMBER], three disposable gowns were hanging on resident closet door while 2 empty hooks were available on the wall. In room [ROOM NUMBER], one gown hang in resident's cabinet door and used gowns were hanging on 3 hooks on the wall. CNA 5 stated she hung the gown to be reused if she needs to provide care to the resident in the room. CNA 5 stated I do not know the process but that's (gown) what I do at the start of my shift. CNA 5 stated she was trained by the nurse to hang the gown on the door of the resident's closet. CNA 5 Stated hanging the gown on the cabinet door is not a good infection control practice. During an interview with Infection Preventionist (IP), on 7/16/20, at 2:25 p.m., in the yellow zone, IP stated the reusable gown should not be hung on top of resident's door cabinet. IP stated it could cause cross contamination between resident's gown and cabinet door from the contaminated gown. During a review of facility policy and procedure COVID-19 Addendum to Outbreak Management, revised 3/11/2020 indicated, .Policy: The facility will conduct education, surveillance and infection control and prevention strategies to reduce the risk of transmission of the novel Coronavirus (2019-nCoV) .3. If both exposure and illness are present, airborne isolation is required .b. Isolate the person with door closed . During a review of a professional reference retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html titled, Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection dated 5/22/2020, indicated, Establish Reporting within and between Healthcare Facilities and to Public Health Authorities Implement mechanisms and policies that promote situational awareness for facility staff including infection control .Patient Placement. For patients with COVID-19 or other respiratory infections .If admitted , place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection .with the door closed .

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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