STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. BUILDING _____ B. WING _____	**09/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAKEPORT POST ACUTE	**1291 CRAIG AVENUE LAKEPORT, CA 95453**

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 -** Few	**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 ensure staff followed infection control practices when 1 of 3 nurses (Nurse A) did not perform hand hygiene immediately after removing gloves and did not change gowns for each resident care. This failure had the potential to spread germs and Coronavirus (COVID-19- is a respiratory illness caused by [MEDICAL CONDITION]) to non-affected residents and staff. Findings: During an observation and interview on 9/21/2020, at 1:23 p.m., Nurse A was wearing N95 respirator mask, face shield, gown and gloves when she went inside Room A, and swabbed Resident 1's nostril to collect specimen for COVID-19 testing. Nurse A put the swab inside a plastic bag, left the room, and put collected swab in a container basket together with other plastic bags containing swabs. Nurse A removed her gloves, and gowns; without performing hand hygiene (hand washing or use hand sanitizer), Nurse A put a glove on her right hand and held the container basket with her right hand. Nurse A went to the lobby and then to the Nurse Station where she put the bags inside the refrigerator. Nurse A washed her hands after. When asked about hand hygiene, Nurse A stated it should be done between every resident. When mentioned about not doing hand hygiene after collecting specimen from Room A, Nurse A stated, I should have sanitized in between residents. When asked about using gowns, Nurse A stated she used one gown in one hallway (when swabbing residents located in one hallway). Nurse A stated COVID testing (collecting speciment for the COVID 19 test) is considered resident care and she should have changed gown for each resident. During an interview on 9/21/2020, at 3:33 p.m., the DON stated staff should change gowns and gloves for each resident contact. Review of Centers for Disease Control and Prevention (CDC) guidance titled Using Personal Protective Equipment (PPE) updated 8/19/20, indicated to Healthcare Personnel should perform hand hygiene after removing gloves and gowns.

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