STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A427	A. BUILDING _____ B. WING _____	**08/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTWOOD MANOR - FREMONT	**4303 STEVENSON BOULEVARD FREMONT, CA 94538**

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 their infection control policy and procedure to prevent spread of infection in the facility during a novel Coronavirus Disease (COVID 19- a mild to severe respiratory (lung) illness) outbreak (an occurrence of disease greater than expected at a particular time and place) when: 1. One staff member did not observe hand hygiene procedures: Program Coordinator 1 (PC 1) did not perform hand hygiene when caring for two residents (Residents 51,52). 2. Contaminated Personal Protective Equipment (PPE) was discarded into open containers in the units for COVID-19 positive (residents with confirmed case of COVID-19 infection) and PUI residents (Persons Under Investigation, a person whose infection status is unknown, so is a potential risk for COVID infection transmission). These failures had the potential to result in the spread of COVID-19, and COVID-19 related complications, up to and including death. Findings: 1. During a concurrent observation and interview on 8/6/20, at 11:12 a.m., with Infection Preventionist 1 (IP 1) and Infection Preventionist 2 (IP 2), in the facility's West Wing, Program Coordinator 1 (PC 1) carried a meal tray into Resident 51's room, placed the meal tray on Resident 51's bedside table, and then moved Resident 51's bedside table with gloved hands. PC 1 then exited Resident 51's room, and without removing gloves and or performing hand hygiene, grabbed a cup of liquid from the hallway meal cart, and delivered the cup to Resident 52's room. PC 1 exited Resident 52's room, and while still wearing the same gloves, picked up another meal tray from the meal cart and delivered it to Resident 52's room. IP 2 stated staff should remove gloves and perform hand hygiene after providing care to one resident. IP 2 stated it was not acceptable to wear the same gloves to provide care for multiple residents. Review of facility's policy and procedure titled, Hand Hygiene, dated 5/18/20 showed, Alcohol Based Hand Rub (ABHR) formulations in the range of alcohol concentrations recommended by CDC, inactivates [DIAGNOSES REDACTED]-CoV-2. Apply ABHR frequently throughout the shift . after touching potentially contaminated surfaces, after using the restroom, before eating or serving food and prior to leaving work. During a review of the facility policy and procedure (PNP), Coronavirus (COVID-19) Prevention and Management, dated 5/21/2020, the PNP indicated, Change gown and gloves, wash hands between patients and patient rooms. 2. During an observation on 8/6/20, at 11:15 a.m., with IP 1 and IP 2, in the West Wing PUI area, PC 1 removed gloves previously used for resident care, and disposed of them in an open (unlidded) trash receptacle, adjacent to the hallway medication cart. During an observation on 8/6/20, at 11:22 a.m., with IP 1 and IP 2, in the Nursing station of the PUI section of West Wing, Registered Nurse 1 (RN 1) removed a gown worn while delivering meal trays to residents, and disposed of the gown in an open (unlidded) trash receptacle. RN 1 stated they did not have trash receptacles with lids in the PUI area. During an interview on 8/6/20, at 11:15 a.m., with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated trash bins were open (unlidded) and were located in the bathrooms of all nine designated rooms for PUI residents. During a concurrent observation and interview on 8/6/20, at 11:46 a.m., with IP 1 and Licensed Vocational Nurse 3 (LVN 3), in the West Wing designated area for COVID-19 positive residents, eight cardboard boxes with black plastic liners, and without lids, were located throughout the hallway. Inside the boxes were discarded gowns, gloves, medication cups, and disposable meal service containers. LVN 3 stated staff used the cardboard boxes to dispose of used PPE and other waste products in that unit. During a review of the facility policy and procedure (PNP), Coronavirus (COVID-19) Prevention and Management, dated 5/21/2020, the PNP indicated for confirmed or suspected cases of COVID-19, Place trash can with lid by the exit door in resident's room.

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