STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555355	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VINTAGE FAIRE NURSING & REHABILITATION CENTER	**3620 B DALE RD. MODESTO, CA 95356**

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 a safe environment with an effective infection prevention and control program for the prevention of [MEDICAL CONDITION] (COVID-19- a contagious serious respiratory infection transmitted from person to person) transmission when the Screener (a person stationed at the entrance of a facility to ask questions and take staff/visitor temperatures) did not ask if visitors had COVID-19 related symptoms as indicated on the facility's screening tool. This deficient practice potentially placed the residents and staff at risk for the spread and transmission of COVID-19, complications from COVID -19 and death. Findings: During a concurrent observation and interview on 7/16/20, at 9:30 a.m., the entry of the facility with a Screener was observed. The Screener asked the survey team if they felt sick, had a fever, had been out of the country, tested positive for COVID or had been around anyone who was COVID positive, and then checked the surveyors' temperatures. One of the surveyors asked the Screener if she had any other questions and the Screener replied, No. During an interview on 7/16/20, at 10:30 a.m., with the Infection Preventionist (IP), the IP stated the expectation of the Screener was to ask visitors if they had any of the COVID-19 related symptoms indicated on the facility's screening tool. The IP stated the screening tool included flu like signs and symptoms, recent travel, contact with known or suspected exposure, had the individual been tested for COVID-19, and temperature check. The IP stated if staff or visitors responded Yes to any of the signs or symptoms, the individual would not be allowed access into the facility and the Screener was to contact the IP immediately. The IP stated, the Screener should have asked visitors that entered the facility, each sign and symptom listed on the facility's screening tool and not just ask if they Felt sick. The IP stated, signs and symptoms of COVID-19 could be missed when the questions on the screening tool are not asked. The IP stated, this (failure) could spread [MEDICAL CONDITION]. During a concurrent interview and record review on 7/16/20, at 10:40 a.m., with the IP, the STAFF / ESSENTIAL VISITOR PRE-VISIT SCREENING TOOL . (Facility Screening Tool), undated, was reviewed. The STAFF / ESSENTIAL VISITOR PRE-VISIT SCREENING TOOL . indicated, .Have you had any flu like symptoms such as: fever, shortness of breath, feeling febrile, headache, nausea, vomiting, or diarrhea or new or change in cough and sore throat . A request was made for the facility's policy and procedure (P&P) related to visitor screening. The facility was unable to provide a P&P prior to exit. During a professional reference, review retrieved on 7/27/20, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-reccomendations.html dated 7/15/20, titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, indicated, .Screen everyone (patients, HCP (health care providers), visitors) entering the healthcare facility for symptoms (Fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea) consistent with COVID-19 or exposure to others with [DIAGNOSES REDACTED]-CoV-2 (COVID-19) infection and ensure they are [MEDICATION NAME] source control .

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.