STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056035	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHAFTER NURSING CARE	**140 EAST TULARE AVENUE SHAFTER, CA 93263**

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 COVID-19 (a mild to severe illness that is caused by a Coronavirus, is transmitted chiefly by contact with infectious material (such as respiratory droplet) and is can be characterized by fever, cough, and shortness of breath and may progress to pneumonia and [MEDICAL CONDITION]) infection control practices when: 1. One Housekeeper (HSK) had not been properly trained to mix disinfecting solution. 2. Medical equipment was improperly stored. 3. One plastic bag which contained residents' personal belongings was stored on the floor. 4. One facility staff did not perform proper hand hygiene. These failures had the potential to result in the spread of COVID-19 infection to residents and staff. Findings: 1. During a concurrent observation and interview on [DATE], at 9:50 AM, with HSK 1, HSK 1 mopped the hallway floor on the facility COVID 19 positive unit. HSK stated, We use bleach, just a little bit, we mix it with water. I measure it 10 to 1, 10 ounces (unit of measurement) of bleach and the rest is just water. When adding bleach to water used to mop the floors HSK 1 stated she fills the mop bucket up with water to the line that indicates two gallons; she then adds three ounces of bleach into the water. HSK 1 stated she then adds some heavy duty cleaner from the janitors' closet to the bleach and water mixture. The Centers for Disease Control Prevention for Coronavirus Disease 2019 (COVID-19), titled Cleaning and Disinfection for Community Facilities, dated [DATE], indicated, How to Clean and Disinfect . Additionally, diluted household bleach solutions (at least 1000 (part per million) sodium hypochlorite, or concentration of 5%-6%.) can be used if appropriate for the surface. Follow manufacturer's instructions for application, ensuring a contact time of at least 1 minute, and allowing proper ventilation during and after application. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser. Unexpired household bleach will be effective against coronaviruses when properly diluted. Bleach solutions will be effective for disinfection up to 24 hours. Prepare a bleach solution by mixing: 5 tablespoons (,[DATE] cup) bleach per gallon of room temperature water or 4 teaspoons bleach per quart of room temperature water . 2. During a concurrent observation and interview on [DATE], at 10:24 AM, with the Administrator and the Infection Preventionist (IP), in the shower room on the facility's COVID-19 positive unit (units designated to be used and occupied by residents who tested positive for COVID-19). A three-tiered cart had medical supplies (three boxes of foam dressing, two boxes of adhesive island wound dressing, one open package of woven sponges, three bottles of sterile normal saline 100 ml (milliliters - unit of measure) and resident care supplies (four bottles of peril care spray, six bottles of deodorant) stored in close proximity to a blue trash can. The IP stated, This is were we store are supplies. The facility policy and procedure for proper storage was requested, none was provided. 3. During a concurrent observation and interview on [DATE], at 10:26 AM, with the Administrator and the IP, a bag of resident personal clothing was stored on the floor at the foot of Resident 1's bed, on the facility's COVID-19 positive unit. IP stated the bag of clothing belonged to Resident 1. IP stated the bag of clothing should not have been stored on the floor. During a review of the facility's policy and procedure (P&P) titled, Inventory List, Resident's Personal, dated 2006, the P&P indicated, 4. Store all items in appropriate place. 4. During an observation on [DATE], at 10:22 AM, in wing B, Licensed Vocational Nurse (LVN) 1 was observed coming out of a resident room and entering into another resident room without performing hand hygiene. During an interview on [DATE], at 10:30 AM, with LVN 1, LVN 1 stated hand hygiene should be performed when entering and exiting a resident's room. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, (undated), indicated, 7. Use an alcohol-based hand rub . for the following situations: a. before and after direct contact with residents.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen e-tanks (used for the storage of oxygen for medical administration) were stored in a safe manner. This had the potential to cause harm to residents and staff. Findings: During an observation, on 7/29/20, at 10 AM, outside of room [ROOM NUMBER], two oxygen e-tanks were standing on the right side of a resident's bed. One oxygen e-tank was not secured. Licensed Vocational Nurse (LVN) 1 carried the unsecured oxygen e-tank out of room [ROOM NUMBER] into the shower room. Inside the shower room, approximately four feet from the door, were two e-tanks unsecured. Multiple e-tanks were stored on the shower room wall near the tub; 14 e-tanks were insecurely stored in the shower room. There was no signage posted on the shower room door to indicate oxygen e-tanks were stored inside. During an interview on, 7/29/20, at 10:17 AM, with Administrator, Administrator stated the oxygen e-tanks were stored in the shower room because the oxygen storage room was on the non-COVID side of the building. He stated, We have a stand and when it got full they (staff) did not notify us (administration) it was full. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration undated, the P&P indicated, EQUIPMENT: Safety strap or chain if using oxygen cylinder on a stand . 4. When using oxygen cylinders, secure oxygen cylinder at bedside per facility procedure.

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.