STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055516	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR CHICO CARE CENTER	**188 COHASSET LANE CHICO, CA 95926**

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.** Based on observation, interview and record review, the facility failed to ensure that staff were trained and competent in disinfecting disposable isolation gowns for extended use when Certified Nursing Assistant (CNA) 2 did not disinfect her gown after providing patient care and when Licensed Nurse (LN) 1 was unable to demonstrate how or when to disinfect her gown. This failure put residents at risk of being exposed to infection or contagious illness such as COVID-19, which can be life-threatening. Findings: A review of a facility policy, titled, Optimizing the Supply of Personal Protective Equipment (PPE), created 6/6/20, indicated that staff would be trained on the appropriate doffing (removing) of PPE and be able to demonstrate competency. During concurrent observation and interview on 8/12/20, at 8:45 AM, while on a tour of the facility, the Director of Nursing (DON) stated that following confirmation of a staff member testing positive for COVID-19, the facility had transitioned all resident rooms to droplet precaution isolation and required staff to wear full PPE. DON stated this included N95 respirator facemasks, gloves, gowns, and eye protection. DON confirmed that the gowns observed hanging by each resident room doorway were to be wiped down and disinfected after each use. During an interview on 8/12/20, at 9:05 AM, the Infection Preventionist (IP) stated that the facility was rapidly using their supply of gowns, had implemented extended use of gowns in accordance with CDC recommendations, and had specified that staff would be limited to the use of one gown per staff member, per room, per shift. IP stated that staff had been educated and trained to disinfect each gown with peroxide wipes between caring for individual residents and prior to removing the gowns to be hung at the entrance to the room upon completion of care. During an interview on 8/12/20, at 10:05 AM, CNA 1 stated she had received education at several inservices on the facility's expectations regarding use of PPE. CNA 1 stated that she had been instructed to wipe down disposable gowns between resident use and that each room had containers of disinfectant wipes out of the reach of the residents, for staff to use. CNA 1 stated that after caring for residents in a room, she would wipe down her gown, remove it and hang it by the door. During a concurrent observation and interview on 8/12/20, at 10:15 AM, CNA 2 stepped out of a room on Unit One after completing resident care, removed her gown and hung it by the door. CNA 2 was observed to not wipe down or disinfecting the gown prior to removing it. When CNA 2 was asked if she had wiped down the gown, she stated she had not. When asked what the facility's expectation was about disinfecting gowns between or after resident care, CNA 2 stated that gowns only needed to be wiped down if visibly soiled, otherwise gowns only needed to be wiped down at the end of the shift. During an interview on 8/12/20, at 10:45 AM, the Director of Staff Development (DSD) stated that the facility was low on gowns and staff had been told to conserve them as much as possible. DSD stated that to do so, staff were expected to reuse one disposable gown per room and discard them at the end of their shift. DSD stated that they had started to bag the gowns at the end of the shift and reuse them an additional day. DSD stated it was important that all staff disinfect their gowns between caring for residents and prior to removing them. DSD stated that a gown should never be left unwiped (not disinfected) until the end of a shift and that CNA 2 should have wiped down her gown with disinfectant before leaving the resident's room. During a concurrent observation and interview on 8/12/20, at 11:00 AM, Licensed Nurse (LN 1) was preparing to enter a patient room on Unit two and had just put on a new gown. LN 1 was asked to explain the process for disinfecting the gown. LN 1 stated she did not know. When asked if she had received education and training on use of PPE and the current expectation for extending the use of gowns, she said she had but could not recall the steps required for cleaning the gowns. When asked to point out or describe what she would use in the room to wipe down a gown, LN 1 was unable to do so. LN 1 stated she did not know where the wipes were or how often she should clean her gown.

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.