STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055107	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BANCROFT HEALTHCARE CENTER	**1475 BANCROFT AVENUE SAN LEANDRO, CA 94577**

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 -** Many	**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 operationalize infection control policies and failed to utilize sanitizing and/or disinfecting agents in accordance with manufactures directions. Failure to change mop heads between rooms has the potential to carry infectious microorganisms from potentially contaminated resident rooms to other resident rooms. Additionally, failure use disinfecting products in accordance with manufactures directions may lead to a false belief that resident care equipment shared by multiple residents has been disinfected which could contribute to health care acquired infections. Findings include: On June 23, 2020 near 1:30 PM, Staff 2 explained and demonstrated how she typically completed the cleaning of resident rooms. The supervisor (Staff 1) of Staff 2 was also present during the entire demonstration & discussion. Staff 2 continued to verbalize the typical resident room cleaning, sweeping and moping process and stated the wet contact times of the cleaning agents that she used. A simultaneous observation of Staff 2's cleaning cart revealed it contain one mop handle and one mop head attached to the mop handle that was submerged in the mop bucket solution. During further interview Staff 2 stated that she used the same mop water and mop head for at least 2-3 rooms. A facility policy titled HOUSEKEEPING HANDLING, STORAGE, TRANSPORTATION AND PROCESSING OF LINENS dated July 08, 2008 states Mop Heads: These are cleaned daily (removed from handles), washed in washing machine in the morning and hug on the line outside to dry. While another facility policy titled Laundry department procedures, which was undated, states clean the water after cleaning each room. On June 24, 2020, near 9:30AM Staff 2 was again observed cleaning resident room [ROOM NUMBER]. Near that same time during an interview with Staff 2, she acknowledged she discarded the mop water but did not change the mop head. During further inquiry, Staff 2 validated (in the presence of the DON/Infection Control Nurse and her supervisor (Staff 2)) the same mop head was being used to mop several rooms. The DON and Administrative Staff 3 educated Staff 1 and Staff 2 indicating that as of June 23, 2020 each resident room should be mopped with a different mop head to help prevent the spread of microorganisms. On June 23, 2020 near 2:45PM, separate observations and interviews occurred with three Certified Nurses Assistants (CNAs) regarding the disinfection of shower chairs between residents. CNA3 revealed he/she used bating soap to disinfect the shower chairs between resident usages. CNA3 denied receiving training or a recent in-service regarding the disinfection of shower chairs between residents. The Administrator and Director of Nurses (DON) were subsequently informed of the aforementioned and were requested to provide the facility policy on the disinfection of shower chairs between resident usages. There was no denial or concurrence of the use of bathing soap as an acceptable way to disinfect shower chairs between resident usages. The procedure on the disinfection of shower chairs between resident usages was not provided by the end of the survey exit. On June 24, 2020, near 10:00 Staff 4 was interviewed regarding the process he/she utilized to disinfect the Hoyer Lift between resident usages. A Hoyer Lift is a mobility tool used to help seniors and others with mobility challenges get out of bed or the bath and allow a person to be lifted or transferred with a minimum of physical effort. CNA4 stated he/she would use Micro Kill Bleach wipes to disinfect the Hoyer Lift; CNA4 further described the wet contact time to be 5-10 seconds. After reading the directions for use CNA4 acknowledged all items, being disinfected with the Micro-Kill needed to remain wet from 30 seconds up to 3 minutes. Under the directions for use the Medline MICRO-KILL Bleach GERMICIDAL BLEACH WIPES states A 30 second contact time is required to kill all of the bacteria [MEDICAL CONDITION] .

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.