STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555578	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HOLIDAY MANOR CARE CENTER	**20554 ROSCOE BLVD CANOGA PARK, CA 91306**

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 ensure the implementation of the infection prevention and control program by one staff not performing hand hygiene in between Residents 1 and 2. This deficient practice placed the resident at risk for infection and cross contamination; and had the potential to result in the spread of Coronavirus Disease 2019 (COVID-19 a [MEDICAL CONDITION] infections that affects the respiratory system and easily transmit from person to person). Findings: A review of Resident 1's Admission Record (Face Sheet) indicated a re-admitted d 6/05/2019, with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS - standardized assessment and screening tool) dated 7/1/2020, indicated the resident was unable to make decisions and required extensive assistance with personal hygiene On 7/14/2020 at 1:10 p.m., during an observation of Residents 1 and 2 with the Director of Nursing (DON) and the Infection Preventionist (IP) Nurse, the Activity Director (AD), wearing gloves, sprayed Resident 1's hands with a hand sanitizer. The AD held Resident 1's hands and assisted the resident with rubbing the sanitizer on his hands. The AD did not remove his gloves and proceeded to assist Resident 2 with spraying the hand sanitizer and rub the resident's hands. The AD did not remove the gloves and did not perform handwashing between assisting the two residents. The AD did not remove gloves after assisting Resident 2 and before leaving the residents's room. At 1:15 p.m., during an interview, the AD stated he forgot to remove his gloves and wash his hands in between providing hand hygiene to Residents 1 and 2 and before leaving the room. On 7/14/2020, at 3:32 p.m., during an interview, the DON stated Activity staff were assigned to sanitize the residents' hands every two hours as part of the facility Infection Control and Prevention Program. The DON stated the assignment was supposed to be a no contact assignment and the residents to be instructed to rub hands together after the staff sprays the sanitized. If residents were unable to follow directions, staff may use gloves and assist the residents in rubbing their hands.

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.