STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055150	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR MANOR REHABILITATION CENTER	**3806 CLAYTON ROAD CONCORD, CA 94521**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of four sampled residents (Residents 2 and 3) were provided assistance with personal hygiene tasks, such as shaving, which resulted in Residents 2 and 3 having overgrown facial hair. This failure had the potential to cause low self-esteem and embarrassment for both residents. Findings: During a review of Resident 2's Admission Record (AR), the AR indicated Resident 2 was admitted to the facility with multiple diagnoses, including a fracture of an unspecified lumbar vertebra (spine) and muscle wasting and atrophy. During a review of Resident 2's Minimum Data Set (MDS, an assessment tool used to guide care), dated 10/18/19, the MDS indicated Resident 2 had intact cognition. The MDS also indicated Resident 2 needed the extensive assistance of at least one staff member for personal hygiene and grooming. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility with multiple diagnoses, including [MEDICAL CONDITION] and chronic pain. During a review of Resident 3's MDS, dated [DATE], indicated Resident 3 had moderately impaired cognition. The MDS also indicated Resident 3 needed extensive assistance of at least one staff member for personal hygiene and grooming. During a concurrent observation and interview on 1/23/20, at 9:15 a.m., in Building 2, with Residents 2 and 3, Resident 2 was seen wearing clean clothes, sitting in a wheelchair across from the Nursing Station, and had overgrown facial hair. When asked about his facial hair, Resident 2 rubbed his face and smiled but was unable to express himself because of a language barrier. Resident 3 was also seen with overgrown facial hair. Resident 3 stated he needed help shaving. During an interview on 1/23/20, at 9:20 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated, These residents (Residents 2 and 3) need to be shaved. LVN 1 indicated Certified Nursing Assistant 1 (CNA 1), who was responsible for shaving these two residents, was giving a shower at this time. During an interview on 1/23/20 at 9:45 a.m., with the Director of Staff Development (DSD), DSD stated grooming, including shaving, should be done during the morning care. DSD indicated Residents 2 and 3 should have been shaved before leaving their rooms that morning. During an interview on 1/23/20, at 10:30 a.m., with CNA 1, CNA 1 indicated she did not shave Residents 2 and 3 that morning but would shave them later. CNA 1 stated she would not like it if she came out in public not groomed nicely. The facility's policy and procedure (P&P) titled, Shaving the Resident, dated 11/12, indicated it was the policy of the facility, to ensure that residents are clean and well-groomed daily, and that unwanted facial hair is removed to improve appearance and morale. The facility's P&P titled, Resident Care, Routine, dated 11/12, indicated, Perform grooming tasks for those residents unable to function independently. These tasks usually include daily shaving for male residents during morning care.
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 follow standard infection prevention and control practices when: 1. Licensed Vocational Nurse 2 (LVN 2) did not wash her hands between glove changes during treatment of [REDACTED]. 2. Certified Nursing Assistant 2 (CNA 2) removed the trash from the isolation room with her bare hands. These failures had the potential to spread illnesses and infections to other residents, staff, and visitors to the facility. Findings: 1. During an observation on 1/23/20 at 11:20 a.m., an isolation cart was seen outside of the room of a resident on isolation precautions. The room's resident, Resident 4, was in bed behind a privacy curtain while LVN 2 was performing a wound dressing change. LVN 2 removed her soiled gloves, went to the isolation cart outside of the room and retrieved some dressing supplies, donned a new pair of gloves, returned to the resident, and resumed the dressing change, all without washing her hands. After the dressing change was completed, LVN 2 removed her gloves then washed her hands. During an interview on 1/23/20, at 11:40 a.m., with LVN 2, LVN 2 stated, I should wash my hands every time I remove and put on a new pair of gloves. 2. During an observation and concurrent interview on 1/23/20, at 11:50 a.m., CNA 2 was seen inside the room of a resident on isolation precautions and wearing Personal Protective Equipment (PPE, protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection). While still in the isolation room, CNA 2 touched and removed the trash from one bin and put it in another bin using her bare hands. During an interview on 1/23/20, at 12:15 p.m., with the Director of Staff Development (DSD), DSD indicated staff should wash their hands before and after wearing gloves. DSD stated, It is part of infection control and prevention. During a review of the facility's policy and procedure (P&P) titled, Enhanced Standard Precaution, dated 1/10/19, the P&P indicated, Hand hygiene is the single most important precaution to prevent the transmission of infection from one person to another.During care, change gloves after having contact with infective material (i.e., fecal material or would drainage which may contain high concentrations of microorganisms). Change gloves when moving from one site to another (i.e., oral care, dressing change).Hand hygiene should be performed before donning and after removal of gloves each time gloves are used. During a review of the facility's P&P titled, Gloves, Wearing (Non-Sterile), dated 1/10/19, the P&P indicated, Hands must be washed every time gloves are removed.

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.