STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056082	A. BUILDING _____ B. WING _____	**10/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CANYON SPRINGS POST-ACUTE	**180 NORTH JACKSON AVENUE SAN JOSE, CA 95116**

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.** Based on observation, interview, and record review, the facility failed to implement infection control measures when: 1. The housekeeping staff (HS) did not remove her gloves before performing the next task; 2. The licensed vocational nurse (LVN) did not properly wear an N-95 (high filtering mask); 3. The LVN did not remove gloves after locking the medication cart (highly touched surface) and before assisting a resident; 4. The facility's back-up infection preventionist (IP, professional who makes sure healthcare workers and residents are doing all the things they should to prevent infections) had not completed the specialized training to become an IP. These failures had the potential to put residents and staff at risk for contracting COVID-19 (Coronavirus disease 2019; a new respiratory infectious disease). Findings: 1. During a concurrent observation and interview on 10/27/2020 at 12:14 p.m., with the HS, she wore gloves while doing housekeeping chores in a resident's room. A staff called her and requested a plastic bag. The HS came out from the resident's room without removing her gloves and proceeded to a supply room to get a plastic bag. The HS confirmed the above observation and stated she should have removed her gloves before coming out of the resident's room. During an interview on 10/27/2020 at 2:34 p.m., with the director of nursing (DON), she stated wearing gloves in the hallway was not allowed. Review of the facility's policy, Personal Protective Equipment- Gloves dated July 2009, indicated gloves should be discarded in the room which the procedure was performed. 2. During an interview on 10/27/2020 at 1:25 p.m., with the DON, she stated when the IP was off for two weeks, she was the back-up IP and the facility's two assistant director of nursing (ADON). The DON confirmed she was not done with her specialized training to become an IP. The DON further stated her two ADON's had not taken the specialized training to become an IP. The facility's mitigation plan was reviewed on 10/27/2020. The mitigation plan did not specify training requirements that an IP needed to meet. However, the mitigation plan did indicate, The guidance the infection preventionist will follow will be heavily influenced from the LHD (local health department), CDPH (California Department of Public Health), and the CDC (Centers for Disease Control and Prevention). Review of All Facilities Letter 20-52, dated 5/11/2020, indicated The SNF (skilled nursing facility) must have a full-time, dedicated Infection Preventionist (IP). This can be achieved by more than one staff member sharing this role, but a plan must be in place for infection prevention quality control. CDPH's Healthcare-Associated Infections Program has developed training materials for SNF IP staff. The SNF must ensure HCPs receive infection prevention and control training and can work with the department to develop a reasonable implementation timeline and plan to bring on the necessary IP staff. 3. During an observation on 10/27/2020 at 3:08 p.m., the LVN was wearing an N95 with straps crisscrossed (bottom strap above the head and the top strap was below the head). During an interview on 10/27/2020 at 3:10 p.m., with the LVN, she confirmed the above observation and stated crisscrossing the straps on the N95 mask was ok as long as it was tight. Review of the Centers for Disease Control and Prevention (CDC) website https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf indicated Do not crisscross straps. 4. During an observation on 10/27/2020 at 3:08 p.m., in the hallway near the facility's main entrance, the LVN wore gloves, took a facemask from the medication cart, locked the medication cart, and proceeded to assist a resident to don the facemask. The LVN did not remove her gloves and did not perform hand hygiene after locking the medication cart, before assisting the resident. During an interview on 10/27/2020 at 3:10 p.m., with the LVN, she confirmed the above observation and stated she should have removed her gloves and performed hand hygiene after locking the cart, before assisting the resident. Review of the CDC website https://www.cdc.gov/handhygiene/providers/index.html indicated, Perform hand hygiene before touching a patient.

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.