STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A340	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTWOOD MANOR - 104	**1130 MONACO COURT STOCKTON, CA 95207**

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 -** Few	**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 provide infection prevention and control measures to prevent the possible spread of COVID-19 when: 1. Staff did not properly disinfect (to clean an object in order to destroy bacteria) resident care equipment between resident (RES) 1, RES 2, RES 3, RES 4, and RES 5; and 2. Staff did not perform hand hygiene (act of cleaning one's hands to remove harmful and unwanted substances) when indicated for resident (RES) 1, RES 2, and RES 3 and remove gloves when indicated prior to providing care to RES 1. This failure put residents at risk of contracting COVID-19, with the potential of causing illness or death. Findings: 1. During an observation, on 8/3/20, at 3:44 p.m., on Station 3, the Activity Director (AD) cleaned the pulse oximeter (a device that clips onto your finger to measure heart rate and oxygen levels in your red blood cells) and thermometer (device used to check a person's temperature) with an alcohol wipe. The AD then entered RES 1 room with the pulse oximeter and thermometer. The AD came out of RES 1 room, and again cleaned the pulse oximeter and thermometer with an alcohol wipe. The AD then entered RES 2 room with the pulse oximeter and thermometer. The AD came out of RES 2 room, and again cleaned the pulse oximeter and thermometer with an alcohol wipe. The AD then entered RES 3 room with the pulse oximeter and thermometer. During an interview, on 8/3/20, at 3:49 pm., with the AD, the AD stated, resident care items were cleaned after use with an alcohol swab and was not certain if there was a specific contact time for the cleaning material to stay on the item before reusing it again. During an interview, on 8/3/20, at 4:06 p.m., with Licensed Nurse (LN) 1, the LN 1 stated proper cleaning of resident care equipment, including the pulse oximeter and thermometer, between resident use would be to use bleach wipes. The LN 1 explained cleaning the reusable resident equipment with an alcohol wipe was not acceptable. During an observation, on 8/3/20, at 4:22 p.m., on Station 2, Certified Nurse Assistant (CNA) 1 checked RES 4's vital signs with a portable vital signs machine in room [ROOM NUMBER]. CNA 1 exited room [ROOM NUMBER] and without cleaning the portable vital sign machine, entered room [ROOM NUMBER]. CNA 1 placed a paper on the bed in room [ROOM NUMBER], checked RES 5's vitals with the portable vital sign machine, picked up the paper, and exited the room. During an interview, on 8/3/20, at 4:29 p.m., with CNA 1, CNA 1 confirmed the portable vital sign machine was not cleaned between RES 4 and RES 5. CNA 1 stated the portable vital sign machine should be cleaned with a bleach wipe between resident use. During an interview, on 8/3/20, at 5 p.m., with the assistant director of nursing/director of staff development/infection preventionist (ADON/DSD/IP), the ADON/DSD/IP, stated it was the facility expectation that shared resident care equipment was cleaned between each resident with a disposable wipe with a germicidal (an agent for killing germs or microorganisms) solution on it. Review of the facility's policy and procedure (P&P) titled, CLEANING OF RESIDENT / CLIENT ROOM AND EQUIPMENT, dated 7/1/20, indicated Equipment such as blood pressure cuffs, pulse oximeters .will be sanitized by nursing staff using anti-[MEDICAL CONDITION] / bacterial wipes in between residents. Review of a facility document, used for staff education in-services, titled INFECTION CONTROL: Transmission-Based Precautions, dated 5/26/20, in the section WET TIMES, indicated, BLEACH WIPES .(used to) DISINFECT EQUIPMENT IN BETWEEN RESIDENT USE 2. During an observation, on 8/3/20, at 3:44 p.m., on Station 3, the Activity Director (AD) dropped an alcohol wipe package on the floor. With gloves on, the AD picked up the alcohol wipe and threw it away in a trash bag located on the cart. The AD, with the same gloves on, then cleaned off the pulse oximeter (device that clips onto your finger to measure heart rate and oxygen levels in your red blood cells) and thermometer (device used to check a person's temperature). Without changing gloves, the AD entered room [ROOM NUMBER] and checked RES 1 temperature and oxygen level. The AD exited room [ROOM NUMBER], removed her gloves, and did not perform hand hygiene before putting on a new pair of gloves. The AD then entered room [ROOM NUMBER] and checked RES 2 temperature and oxygen level. The AD exited room [ROOM NUMBER], removed her gloves, and did not perform hand hygiene before putting on a new pair of gloves. The AD then entered room [ROOM NUMBER] again and checked RES 3 temperature and oxygen level. During an interview, on 8/3/20, at 3:46 p.m., with the AD, the AD stated, I cleaned my gloves with an alcohol wipe because I was in a hurry, but explained cleaning the gloves with an alcohol wipe was not a normal procedure. The AD stated, the gloves should have been removed after picking up the alcohol wipe on the floor and new gloves should have been put on before going into a resident's room. The AD explained after gloves are removed, hand hygiene should occur, and stated, I should have done it but, I don't have hand sanitizer and I'd have to wash my hands at the sink. Review of the facility's policy and procedure (P&P) titled Hand Hygiene, dated 5/18/20, indicated staff to perform .hand hygiene before and after providing care to each person served. Hand hygiene is also performed .after touching potentially contaminated surfaces . Review of the facility's P&P titled UNIVERSAL PRECAUTIONS (TOTAL)/ISOLATION/PERSONAL PROTECTIVE EQUIPMENT, (not dated), indicated Change gloves between resident contacts .Do not wash or disinfect surgical or examination gloves for reuse. Review of a facility document titled, When & How to Wear Gloves, dated 3/4/20, indicated, Gloves are not a substitute for hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (putting on) gloves, before touching the patient or the patient environment. Perform hand hygiene immediately after removing gloves.

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.