STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555905	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SERENETHOS CARE CENTER, LLC	**22822 MYRTLE STREET HAYWARD, CA 94541**

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.** Based on observation, interview, and record review, the facility failed to implement facility policies and procedures designed to reduce the spread of novel Coronavirus Disease (commonly known as COVID 19- a mild to severe respiratory (lung) illness) when: 1. Seven of 17 residents' rooms (Rooms A, B, C, D, E, F, G; occupied by Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14) did not have Alcohol Based Hand Sanitizer (ABHS, commonly known as hand sanitizer) readily accessible for staff to use during resident care; 2. Two of 17 resident rooms (Rooms A and B; occupied by Residents 1, 2, 3, 4) had no gloves available inside the room to allow staff to change soiled gloves during resident care provision. 3. Three staff members (Certified Nursing Assistant 1 (CNA 1), Certified Nursing Assistant 2 (CNA 2), and Occupational Therapist 1 (OT 1) did not perform hand hygiene according to policy and procedure. These failures had the potential to result in the spread of COVID-19, and COVID-19 related complications, up to and including death. Findings: During an interview on 8/13/20, at 10:09 a.m., with Chief Executive Officer/Infection Preventionist (CEO/ IP), CEO/IP stated each resident bedroom had gloves and sanitizer available inside the room to comply with infection control policies and procedures. CEO/IP stated the residents in Room B were positive for COVID-19 infection and so had transmission-based isolation precautions in effect (precautions/actions instituted to prevent the spread of infectious agents, based on the means of transmission such as droplets of respiratory secretions, and direct or indirect contact with the resident/resident's environment). During a concurrent observation and interview, on 8/13/20, at 10:35 a.m., with CEO/ IP and CNA 1, a cart containing PPE (Personal protective equipment, protective items or garments worn to protect the body or clothing from hazards that can cause injury or transmission of infective organisms; items include gloves, gown, face masks.) was parked in the hallway outside Bedroom A. CNA 1 donned a pair of gloves from the PPE cart, without performing hand hygiene, and entered Room B carrying several wash cloths. CNA 1 picked up a box labeled gloves from the resident bedside table and turned it upside down and stated the box was empty. CNA 1 also stated there was no hand sanitizer in the room and closed the door. CEO/IP left the vicinity and returned at 10:40 a.m. with a bottle of hand sanitizer just as CNA 1 opened the door and stated she was going to provide personal hygiene care to both residents. CEO/IP handed the bottle of hand sanitizer to CNA 1 and CNA 1 closed the door. During an observation, on 8/13/20, at 10:48 a.m., OT 1 came out of Room C room wearing PPE (a yellow cloth gown, gloves, and a face shield). OT 1 took off his gloves, and without performing hand hygiene, removed the gown, and wiped his face shield with Sani wipes (disinfectant wipes). During a concurrent observation and interview, on 8/13/20, at 10:53 a.m., in the hallway in front of CEO/IP's office, Occupational Therapy Assistant (OTA) exited Room G, and stated the room had no hand sanitizer. CEO/IP came out of her office with bottles of hand sanitizer, and told OTA to put it a bottle inside Room G. CEO/IP also gave bottles of hand sanitizer to Certified Nurse Assistant 3 (CNA 3), who was walking past CEO/IP's office, with instructions to place the bottles in resident rooms. During a concurrent observation and interview, on 8/13/20, at 10:58 a.m., in the hallway, with CNA 3, CNA 3 stated some resident bedrooms did not have hand sanitizer available inside the room. CNA 3 placed the bottles in four resident rooms (Rooms C, D, E, and F), which she stated had not previously had bottles of hand sanitizer. During a concurrent observation and interview, on 8/13/20, at 11:03 a.m., with CEO/ IP and CNA 2, CNA 2, without performing hand hygiene, donned a pair of gloves and collected an adult brief from the PPE cart parked in the hallway outside Room A. CNA 2 entered Room A, and stated she did not have hand sanitizer or gloves inside the resident room, but she was going to change one of the resident's incontinent brief, and CNA 2 shut the door. CEO/IP stated the facility had adequate supplies of gloves and hand sanitizer available, but CEO/IP was not informed by staff when the rooms needed supplies. During a review of the facility policy and procedure (PNP) titled, Hand hygiene/ Hand washing, revised 1/28/20, indicated, Hand hygiene products and supplies (sinks, soap, towels, alcohol-based rub, etc.) shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. A review of the facility's policy and procedure (PNP) titled, Isolation, Initiating Transmission Based Precautions, dated 1/28/20, indicated the Infection Preventionist was responsible to ensure protective equipment and supplies needed to maintain precautions during care are in the resident's room. During a review of the Center for Disease Control article, Preparing for COVID-19 in Nursing Homes, dated 6/25/20, the article indicated, Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym). A review of the facility's policy and procedure (PNP) titled, Hand Hygiene, dated 1/28/20 indicated, The facility considers hand hygiene the primary means to prevent the spread of infections. The PNP indicated hand hygiene, either soap and water or an alcohol based hand rub, must be performed: before and after direct resident contact; before moving from a contaminated body site to a clean body site during resident care; after contact with a resident's skin or blood or body fluids, after removing gloves, or personal protective equipment (PPE). The PNP also indicated, The use of gloves does not replace hand hygiene procedures Perform hand hygiene before applying non-sterile gloves.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE