STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A357	A. BUILDING _____ B. WING _____	**03/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEPT OF STATE HOSPITALS - NAPA D/P SNF	**2100 NAPA-VALLEJO HIGHWAY NAPA, CA 94558**

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 follow infection control practices when: 1. Registered Nurse (RN)1 did not perform hand hygiene between patient care. 2. Psychiatric Technician (PT)1 did not wear gloves during a Gastrostomy Tube ([DEVICE]/A tube inserted through the abdomen into the stomach, used to provide nutrition directly into the stomach.) medication administration. 3. Psychiatric Technician Assistant (PTA) 1 was chewing gum passing out food trays. This failure had the potential to result in transmission of infection to the residents. Findings: 1. During a concurrent observation and interview on 3/9/20 at 12:30 p.m., in room [ROOM NUMBER], with Quality Assurance Registered Nurse (QA RN), Registered Nurse (RN) 1 was feeding Resident 25 his lunch. Psychiatric Technician Assistant (PTA) 2 was feeding Resident 11 his lunch. PTA 1 asked RN 1 for help repositioning Patient 11. RN 1 stopped feeding Patient 25 and walked over and began helping PTA 2 reposition Patient 11. RN 1 did not wash her hands between resident care. QA RN stated, RN 1 should have washed her hands between feeding Patient 25 and repositioning Patient 11. During an interview on 3/11/20, at 2:17 p.m. with Public Health Nurse (PHN), the PHN stated, the facility's expectation was hand hygiene should occur between resident care. Feeding and repositioning a resident was considered resident care. PHN stated, RN 1 should have performed some type of hand hygiene (hand washing or hand sanitizer) between resident care. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene, dated 1/28/20, the P&P indicated, hand hygiene should be performed before and after contact with patients. The P&P indicated, Handwashing or hand decontamination with alcohol-based hand sanitizer before and after contact with each patient is the most important method of preventing the spread of infections. 2. During a concurrent observation and interview of the medication pass on 3/11/20, at 7:50 a.m., Psychiatric Technician (PT) 1 used hand sanitizer for hand hygiene and checked for gastrostomy tube ([DEVICE]) placement on Patient 14. PT 1 stated, she was going to check for tube feeding residue and aspirated contents from the [DEVICE] and returned the contents into the [DEVICE]. PT 1 began administering medications without using gloves. PT 1 stated, she did not know if it was required to wear gloves during medication administration via [DEVICE] but she did use hand sanitizer. During an interview on 3/11/20, at 2:17 p.m. with Public Health Nurse (PHN), the PHN stated gloves are expected to be used when staff come in contact with bodily fluids and/or blood. The PHN stated, staff should wear gloves when they are administering medication via [DEVICE]s. During a review of the facility's policy and procedure (P&P) titled, Standard Precautions, dated 10/15/19, the P&P indicated, gloves are used for contact with no-intact skin and mucous membranes. The P&P indicated, gloves .prevent gross contamination of hands when touching blood, body fluids, secretions, and excretions. 3. During an observation and concurrent interview, on 3/9/20 at 12:20 p.m., Psychiatric Technician Assistant (PTA)1 was observed chewing gum while passing lunch trays in the dining room. PTA 1 was observed opening lids and setting up residents' trays. When asked if he was supposed to be chewing gum while passing trays PTA 1 stated, No, I am not supposed to be chewing gum while passing trays. During an interview with the Standard Compliance Director, on 3/11/20 at 1:55 p.m., regarding chewing gum, he stated the expectation was that staff would not chew gum while working. He stated not only was it an infection control issue, it was for facility safety as residents could potentially use gum to block the locks on doors.

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.