

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 056324	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2020
NAME OF PROVIDER OF SUPPLIER WINDSOR HAMPTON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 442 HAMPTON STREET STOCKTON, CA 95204	
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	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure infection control measures were followed to prevent the occurrence and the spread of COVID-19 when staff did not perform hand hygiene immediately after removal of personal protective equipment (PPE-specialized clothing or other wearable gear, such as mask, face shield, gown, and gloves that minimizes one's exposure to sources of illness or injury). This failure placed residents and staff at risk of contracting and spreading COVID-19, with the potential of causing illness or death. Findings: During an observation on 8/7/20, at 10:12 a.m., an activity assistant (AA), wearing her surgical mask, face shield, gown, and gloves, entered room [ROOM NUMBER], a designated yellow zone room (a space in the facility designated to be used and occupied by asymptomatic residents and/or residents that have unknown testing status). She came out from the resident's room without her gown. While outside room [ROOM NUMBER], the AA then removed her gloves and started pushing her activity cart to another resident's room, without performing hand hygiene immediately after removing her gloves. During an interview with the AA on 8/7/20, at 11:55 a.m., she stated she forgot to perform hand hygiene and should have sanitized her hands after removing her gloves. During an interview with the director of nursing (DON) and assistant DON on 8/7/20, at 12:25 p.m., they both stated, they expected all staff to perform hand hygiene immediately after removing gloves. Review of the facility's policy titled, GLOVES, WEARING (NON-STERILE) revised 1/10/19, indicated, gloves will be changed and hands washed between caring for residents. Gloves are NOT a substitute for hand washing. Hands must be washed every time gloves are removed. Review of the facility's policy titled, Hand Hygiene P & P (policy and procedure) revised 1/10/19, indicated, Employees are required to wash their hands thoroughly .after removing gloves .</p>		

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.