

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 05A277	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/26/2020
NAME OF PROVIDER OF SUPPLIER DYCOR TRANSITIONAL HEALTH-SAN JOSE		STREET ADDRESS, CITY, STATE, ZIP 401 RIDGE VISTA AVENUE SAN JOSE, CA 95127	
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 record review, the facility failed to ensure a visitor was screened for Covid-19 (a disease caused by a new strain of coronavirus) and two kitchen staff did not wear face mask properly inside the kitchen. These failures had the potential to transmit and spread infection to the residents and staff. Findings: During a weekly visits 5/26/2020 at 10:00 a.m., facility did not screened a visitor related to Covid-19 illness. During a kitchen observation on 5/26/2020 at 11:05 a.m., one kitchen staff did not cover her nose with a face mask and another kitchen staff did not cover the mouth and nose with a face mask. During an interview with the director of nursing (DON) on 5/26/2020 at 11:10 a.m., she stated the two kitchen staff should have wear the face mask properly which covered the nose and the mouth. Review of the Center for Disease Control and Prevention dated 2019, How to Protect Yourself and Others, the best way to prevent illness was to avoid close contact with people who are sick and being exposed to [MEDICAL CONDITION]. [MEDICAL CONDITION] was thought to spread mainly from person-to-person through respiratory droplets when infected, person cough, sneeze and talks. Watch for fever, cough, shortness of breath and other symptoms of COVID-19.</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.