

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 555822	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2020
NAME OF PROVIDER OF SUPPLIER CANYON OAKS NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 22029 SATICOY STREET CANOGA PARK, CA 91303	
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. Based on interview, observation, and record review, the facility failed to follow infection control practices when one of four medication nurses, used his personal blood pressure cuff machine on patients during vital signs procedures and did not follow manufacture cleaning and disinfecting recommendations. This failure have the potential in the result of transmission of infection to the residents. Findings: During a facility tour of the facility and concurrent interviewed on July 1, 2020 at 12:40 AM, the licensed nurse, (LN1) stated, I do not use the blood pressure machines from the facility, I use my own LN 1 proceed to show the blood pressure machine. LN 1 did not have the manufacture cleaning disinfecting procedure. During the observation of the blood pressure machine, brand (Name of Blood pressure cuff manufacturer. The blood pressure cuff (BPC) (the part of the cuff that wrap the arms around during the blood pressure check) was dirty and was observed to contained lint, hair, and dark reddish/bluish dots attached to the fussy part of the BPC. During an interview with the infection control nurse (IP) on July 1, 2020, at 12:45 PM, IP stated, Should not have use own machine furthermore the IP stated, It (the BPC) should be cleaned and disinfected Upon policy request, the facility's administration indicated on July 7, 2020, at 4:07 PM (via email), We do not have a policy for staff bringing their own personal medical equipment. This employee should not have brought his own medical equipment.		

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.