STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055735	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR ELMHAVEN CARE CENTER	**6940 PACIFIC AVENUE STOCKTON, CA 95207**

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 observations, interviews, record review, the facility failed to implement and practice current Centers for Disease Control (CDC), California Department of Public Health (CDPH), and facility's Infection control guidelines for the management of COVID-19 when: 1. Person Under Investigation (PUI) residents were cohorted on same unit with negative/recovered COVID- 19 residents; 2. Three residents were observed outside rooms without proper use of facemasks; 3. An ultrasound technician (UST) was observed entering the facility after screening without hand hygiene and required Personal Protective Equipment (PPE); 4. Certified Nursing Assistant (CNA 2) was observed not wearing required PPE while removing a soiled meal tray from a PUI resident's room; 5. Transmission Based Precaution (TBP) signage was not observed on the doorway of a room in the yellow zone with 2 PUI residents (Resident 1 and Resident 2); 6. Symptom screening for one resident (Resident 3) who was a PUI was not conducted every four hours; and 7. Three N95 respirators were used in rotation by facility staff with 72 hours in between reuse. These failures had the potential to jeopardize the health and safety of the residents and staff through the exposure of COVID-19 for a census of 113 residents. Findings: 1. During a concurrent observation and interview with the Infection Preventionist (IP) on 8/7/20 at 11:00 a.m., observation of the hallway from Rooms 22-32 (22,23,25,26,30) had TBP yellow signage posted on the doorways for 5 of 10 rooms. The IP confirmed the marked yellow signage indicated which rooms had PUI residents. The rooms without signage was confirmed by the IP to be green or those of residents with a negative test, had completed quarantine time, or recovered from COVID-19. During an interview with Assistant Director of Nursing (ADON) on 8/7/20 at 10:55a.m., the ADON stated the residents in the yellow and green zones were cohorted in the same hallways. The ADON further stated the residents did not want to change rooms. During a record review, an undated document titled, (Facility Name) COVID-19 Mitigation Plan Manual, revealed Residents in yellow zone will only be cohorted with other asymptomatic unknown residents if no single room is available and Residents in the yellow zone will be restricted to the yellow zone until they have been cleared to enter the green zone. 2. During an observation on 8/7/20 at 11:00 a.m., 3 residents were observed without wearing proper facemasks. Observation revealed 1 resident was wearing a cloth face covering only over mouth and 2 residents were observed with no face covering. During an interview with Licensed Nurse 1 (LN 1) on 8/7/20 at 11:55a.m., the LN 1 stated any resident outside their room must have a mask on. During an interview with the Administrator (ADM) on 8/7/20 at 12:20 p.m., the ADM confirmed that residents in the hallway should be wearing a mask. A review of an undated document titled, (Facility Name) COVID-19 Mitigation Plan Manual, revealed Residents leaving their room will be asked to wear a facemask . A review of CDC webpage document titled, Preparing for COVID-19 in Nursing Homes, dated 6/25/20, revealed Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility . 3. During an observation of the Ultrasound Technician's (UST) COVID-19 entry screening on 8/7/20 at 11:35 a.m., CNA 1 did not ask the UST to complete hand hygiene. CNA 1 had the UST put on face shield, however, did not provide or inform the UST an N95 mask was required to enter the facility. The UST was observed exiting the screening area with a surgical facemask despite doorway signage directing anyone entering facility to wear an N95 mask. During an interview with the CNA 1 on 8/7/20 at 11:40 a.m., the CNA 1 stated she did not know if it was her expectation to ensure people entering the facility have correct PPE. During an interview with the Director of Nursing (DON) on 8/7/20 at 11:45 a.m., the DON stated the expectation is that the screener should prompt persons entering the facility to complete hand hygiene and don N95 and eye protection prior to leaving the screening area. A review of CDC webpage document titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated 7/15/20, revealed the facility should Take steps to ensure that everyone adheres to source control measures and hand hygiene practices while in a healthcare facility and Facilities should provide instruction .on hand hygiene .use of PPE according to current facility policy . 4. During a concurrent observation and interview with the Administrator on 8/7/20 at 12:20 p.m., the CNA 2 was observed exiting a yellow zone room carrying a soiled lunch tray and placing it on a food cart without wearing gloves or a gown. The Administrator confirmed CNA 2 should be wearing the PPE recommended for the yellow zone and verified she was not wearing gloves or a gown at the time she removed the soiled tray from the room. A review of CDC webpage document titled, Responding to Coronavirus (COVID-19) in Nursing Homes, dated 4/30/20, revealed HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents . and All recommended COVID-19 PPE .which includes use of an N95 .eye protection .gloves, and gown. A review of an undated document titled, (Facility Name) COVID-19 Mitigation Plan Manual, revealed All staff will wear recommended PPE while in the building per current, CDC or CDPH PPE guidance. During a record review of the facility document titled, COVID-19 Addendum to Outbreak Management, dated 3/11/20, revealed staff should Wear appropriate personal protective equipment (PPE) - including gloves, gown, mask and eye protection. 5. Resident 1 was admitted in mid-July 2020 with [DIAGNOSES REDACTED]. Resident 2 was admitted in late July 2020 with [DIAGNOSES REDACTED]. During a concurrent observation and interview with the Assistant Director of Nursing (ADON) on 8/7/20 at 11:50 a.m., the ADON confirmed the 4 of 11 (6,7,8,10) rooms within the admission hallway that were observed without doorway yellow zone signage were no longer on Transmission Based Precautions (TBP) and were now considered a green zone. The ADON confirmed Rooms 1-11 was the designated yellow zone in the facility and primarily is used for new admissions. During a record review of the document titled by the Administrator as the Yellow list, dated 8/7/20, revealed Resident 1 and Resident 2 were to be considered in the yellow zone until 8/11/20 as the initiation date of TBP was 7/29/20. During a record review of facility policy titled, Enhanced Standard Precautions, dated 01/10/19, revealed the implementation of enhanced standard precautions included staff to Provide appropriate signage and post outside the door frame where the sign may be easily seen . During a concurrent interview and record review with the IP on 8/10/20 at 4:04 p.m., the IP confirmed Resident 1 and Resident 2 were included in the document titled, Yellow List dated 8/7/20. The IP stated the document is updated daily to provide staff a reference of which residents are on TBP and when it is to be removed. The IP further stated the expectation was for Resident 1 and Resident 2's door to be marked with the yellow TBP signage. 6. Resident 3 was admitted to the facility in mid 2020 with [DIAGNOSES REDACTED]. Resident 3 was identified as a PUI. Review of Resident 3's Progress Notes dated 6/19/20 at 11:48 p.m., indicated, . Resident is on droplet precaution d/t (due to) refusal of COVID-19 test . Review of Resident 3's Progress Notes dated 7/21/20 at 11:30 a.m., indicated, Resident room changed . Review of Resident 3's Medication Administration Record [REDACTED]. If 1 of following, altered mental status from baseline, respiratory rate above 22, SBP below 100, O2 sat below 92%, bluish lips or face; increase monitoring to Q4H. Report change to MD immediately. If 2 or more of above, call MD (Medical Doctor) for potential BLS (Basic Life support) transfer, every shift to be done till COVID recovered. Monitoring for signs and symptoms of COVID-19 was conducted once every shift from 8/1/20-8/7/20. Review of the Resident 3's Order Summary Report dated 8/11/20, indicated, Monitor and assess patient for abnormal signs and symptoms q (every) shift or if COVID Positive Q4: Temperature, Respiratory Rate, 02

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) (oxygen) Saturation, Change in mental status, shortness of breath, heart rate, cough, rhinorrhea, chest pain, diarrhea. If 1 of following, altered mental status from baseline, respiratory rate above 22, SBP below 100, O2 sat below 92%, bluish lips or face; increase monitoring to Q4H. Report change to MD immediately. If 2 or more of above, call MD (Medical Doctor) for potential BLS (Basic Life Support) transfer, every shift to be done till COVID recovered . Order Status . Active . Order Date . 6/4/20 . Start Date . 6/19/20 . During an interview with the ADON on 8/11/20 at 9:08 a.m., the ADON confirmed the COVID-19 monitoring for Resident 3 was conducted once every shift from 8/1/20-8/7/20. The ADON stated Resident 3 was supposed to be on COVID-19 monitoring every 4 hours and further stated it was missed. During an interview with the Director of Nursing (DON) on 8/11/20 at 2:25 p.m., the DON confirmed that they should have changed the order for COVID monitoring to every 4 hours per facility policy for a PUI resident. During an interview with the DON on 8/12/20 at 11:47 a.m., the DON stated COVID monitoring every 4 hours for Resident 3 was started on 6/4/20 and ended on 6/18/20. The DON further stated COVID monitoring for Resident 3 was completed once a shift starting 6/19/20. During a concurrent interview and record review with the IP on 8/11/20 at 2:00 p.m., the IP confirmed Resident 3 was included on the document titled, Yellow List, dated 8/7/20. The IP stated Resident 3 was on the yellow list due to a positive COVID-19 HCP exposure on 8/6/20. The IP further stated a room change was done on 7/21/20 which placed Resident 3 into a room with indefinite PUI monitoring. During an interview with the IP on 8/12/20 at 3:22 p.m., the IP stated Resident 3's rooms have always been in the yellow zone since admission. Review of the facility policy titled, COVID-19 Positive Resident(s) Checklist, revised 7/9/20, indicated, Initiate Contact List . If positive resident(s) had current/recent past roommate(s) and/or other resident/ staff exposure, notify physician and get order to increase COVID symptom monitoring from Q shift to Q 4 (hours) x 14 days . 7. During an interview with the IP on 8/7/20 at 11:07 a.m., the IP stated the facility company makes sure they have two weeks worth of supplies. During an interview with the Administrator (ADM) on 8/7/20 at 12:20 p.m., the ADM stated daily reporting of inventory is completed by the ADM to the corporate office and the facility had adequate supply. The ADM provided the facility map and marked PPE storage. During an interview with the IP on 8/11/20 at 4:00 p.m., the IP stated staff are three N95 respirators to use in rotation with 72 hours between each use, for up to 5 times per N95 respirator. Review of the facility policy titled, COVID-19 . Extended Use of N95 Respirators, revised 7/23/20, indicated, Facility will implement extended use practices for optimization of N95 for a maximum period of 8-12 hours, and five (5) uses per respirator and allowing at least 72 hours between reuse of the same respirator . HCP (Health Care Providers) will be issued a minimum of three (3) N95 respirators each. Staff will be educated to rotate the respirators by using a different one each day worked and allow at least 72 hours between reuse of the respirator . During an interview with the IP on 8/12/20 at 2:55 p.m., the IP stated they follow CDC Guidelines. Review of CDC Guidelines titled, Coronavirus Disease 2019 (COVID-19) . Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators, dated 8/4/20, indicated, . The healthcare staff member can wear one N95 FFR each day and store it in a breathable paper bag at the end of each shift with a minimum of five days between each N95 FFR use, rotating the use each day between N95 FFRs. This will provide some time for pathogens on it to die off during storage . Review of the facility policy titled, COVID-19 Addendum to Outbreak Management, revised 3/11/20, indicated, The facility will follow all State, Local, Federal, and CDC updates and guidance regarding the novel Coronavirus (2019-nCoV).