STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555336	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINGSTON HEALTHCARE CENTER, LLC	**329 REAL ROAD BAKERSFIELD, CA 93309**

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed ensure employees were tested and screened for [MEDICAL CONDITION] (TB - is an infectious disease affecting the lungs). This failure had the potential to spread TB to the residents, employees, and visitors. Findings: During a concurrent interview and review of the employee health records, on 3/20/20, at 3:41 PM, with the Administrator, the [MEDICATION NAME] Skin Testing (TST), TB screening, and chest x-rays were reviewed, the following was noted: Licensed Vocational Nurse (LVN) 1 - TST, dated 12/22/18. LVN 2 - TB screening dated 8/25/18 and a chest x-ray dated 8/5/16. Registered Nurse (RN) 1 - TB screening 2/20/19 and chest x-ray dated 12/6/13. Certified Nursing Assistant (CNA) 1 - TB screening 4/10/19, no TST. CNA 2 - TST - dated 12/29/18, no TB screening. The Administrator verified the findings and stated the Director of Staff Development (DSD) was in charge of ensuring employee health records are kept up to date. He stated the DSD no longer works for the facility. During a concurrent interview and record review, on 8/7/20, at 3:19 PM with the current DSD, stated she was unable to locate any updated records. During a review of the facility's Policy and Procedure (P&P) titled, [MEDICAL CONDITION]-Infection Control Program dated 10/17/19, the P&P indicated, B. Healthcare Professionals (HCPs) . iii. The facility will administer a one-step PPD (test to [DIAGNOSES REDACTED]. If a TST cannot be performed, an IGRA (TB blood test - Interferon Gamma Release Assay) will be obtained if no documented prior TB disease or latent [MEDICAL CONDITION] Infection (LTBI) v. A chest x-ray is not needed unless the employee has tested positive on their PPD skin test or if the employee is known to have latent TB infection and answered positively to questions on TB Symptom Screen Questionnaire .

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.