STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056258	A. BUILDING _____ B. WING _____	08/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR REDDING CARE CENTER	2490 COURT STREET REDDING, CA 96001

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 observation, interview, and record review, the facility failed to follow infection control practices to prevent spread of infection in the facility during a [MEDICAL CONDITION] Disease (COVID-19, a contagious respiratory illness spread by droplets) outbreak. The facility did not follow its COVID-19 mitigation plan, and the Centers for Disease Control (CDC) guidelines relating to COVID-19 infection control, when: 1. A resident was readmitted to a room, with two other residents who had been exposed to COVID-19, by their prior roommate, who had tested positive for COVID-19. 2. Residents who were admitted on different dates, with unknown COVID-19 status, and placed in quarantine, were cohorted three to a room. This caused residents who were admitted earlier to be exposed, when the new roommate was admitted to their room, and because of the new exposure to have to start another 14-day quarantine period. This had the potential to result in the spread of COVID-19 to all residents who resided in the facility as well as staff who worked there, and continuation of the COVID-19 outbreak. Findings: The CDC defined quarantine as, separates and restricts the movement of people who were exposed to contagious diseases to see if they become sick, in their Quarantine and Isolation guidelines, dated 1/27/20. In a document titled, Responding to Coronavirus (COVID-19) in Nursing Homes, dated 4/30/20, the CDC indicated, Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room, or in a separate observation area so the resident can be monitored for evidence of COVID-19 . Newly admitted , or readmitted residents should still be monitored for evidence of COVID-19 for 14-days after admission and cared for using all recommended COVID-19 PPE . Resident with new-onset suspected or confirmed COVID-19: Roommates of residents with COVID-19 should be considered exposed and potentially infected and if at all possible should not share rooms with other residents unless they remain symptomatic and/or have tested negative for 14-days after their last exposure (e.g. date their roommate was moved to the COVID-19 care unit) . Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented. 1. During a tour of the facility on 8/10/20 at 9:15 am, with the Infection Prevention Nurse (IPN), the observation unit (yellow zone) for new admissions, readmissions, or residents who routinely left the facility for [MEDICAL TREATMENT] at outpatient [MEDICAL TREATMENT] centers, was located on Wing 1 with Rooms 23, 24, 28, 29, 30 and 31. The residents who resided in these rooms had an unknown COVID-19 status and were still under the 14-day quarantine. During an interview, on 8/10/10 at 1:30 pm, the IPN said a Certified Nursing Assistant (CNA) from a Nursing Registry (company that supplies temporary short term healthcare staff to facilities) worked at the facility on 7/21/20, through 7/23/20, and entered all the rooms on the observation unit except room [ROOM NUMBER]. The facility was notified by the Nursing Registry that this CNA was positive for COVID-19 on 7/28/20. Testing of all residents began on 7/29/20, and all were negative. A second round of testing on residents began on 8/5/20. Results on 8/6/20, were positive for two residents who were then moved to the COVID-19 positive unit. A second round of testing on all residents was expected to be completed by 8/12/20. IPN said as far as he knows the facility was not been limiting new admissions despite the two positive residents. IPN said, prior to transfer to the COVID-19 unit, Resident 1 had been on the observation unit in room [ROOM NUMBER] C with two other residents (Residents 2, and 3), who had tested negative, but were still under quarantine. He said one of their long term care residents (Resident 4), was admitted to the hospital on [DATE], and was expected to return this afternoon. Patient 4 returned during this interview, and was placed in 29 C with Residents 2, and 3. IPN said the facility's Interdisciplinary Team (IDT) decided what room the resident would be admitted , but he missed the IDT meeting today. He confirmed a readmit, or new admit should not be placed in a room with residents with known exposure to a positive COVID-19 resident. 2. During an interview, and concurrent record review, on 8/10/20 at 1:30 pm, IPN said they were cohorting three residents to a room and some of the residents did not have the same admitted . * Residents 5, 6, and 7 were long term [MEDICAL TREATMENT] residents and were cohorted together in room [ROOM NUMBER]. They all go to the same [MEDICAL TREATMENT] center. * Resident 8's admitted was 6/12/20. She went out for a cast removal and upon return on 7/20/20, was cohorted in room [ROOM NUMBER] with Resident 9 who was also admitted on [DATE]. Resident 10 was admitted to this room on 7/21/20. IPN said at that time if any of the residents went out of the facility for any reason they were quarantined for 14-days when they returned and that was why Resident 8 was placed in quarantine. * Resident 11 was admitted on [DATE], to room [ROOM NUMBER]. No other residents were in that room. * Resident 1 was admitted on [DATE], and went out of the facility for a doctor's appointment on 7/21/20. Upon return he was placed in room [ROOM NUMBER], for quarantine. Resident 2 was readmitted on [DATE], and Resident 3 was admitted on [DATE], and all three patients were cohorted together in room [ROOM NUMBER]. Resident 1 cohorted with Residents 2, and 3 until he was moved out on 8/6/20, after testing positive for COVID-19. A readmission, Resident 4 was placed in this room on 8/10/20. * Resident 14 was a [MEDICAL TREATMENT] patient, readmitted on [DATE], in room [ROOM NUMBER], who went out of the facility frequently to the hospital and was not cohorted with any other resident. * Resident 12 was admitted on [DATE], to room [ROOM NUMBER], and cohorted with Resident 13 who was admitted on [DATE].

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.