STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555354	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DELTA NURSING & REHABILITATION CENTER	**514 NORTH BRIDGE STREET VISALIA, CA 93291**

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 -** Immediate jeopardy **Residents Affected -** Many	**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 prevent the spread of COVID-19 (a mild to severe illness that is caused by a Coronavirus, is transmitted chiefly by contact with infectious material (such as respiratory droplet) and is characterized by fever, cough, and shortness of breath and may progress to pneumonia and [MEDICAL CONDITION]) infection when: 1. Five of five sampled staff (Licensed Vocational Nurse/Personal Protective Equipment Coach (LVN/PPEC) 1, Certified Nursing Assistant (CNA) 2, Licensed Vocational Nurse (LVN) 1, CNA 1 and LVN/PPEC 2) used N95 masks (a type of respiratory device which removes particle from the air that are breathed through it) several days consecutively without rotation and training on reuse of N95; 2. Used face shields (a mask typically made of clear plastic that protects the mucous membranes of the eyes, nose, and mouth during patient-care procedures and activities that carry the risk with generating splashes of blood, body fluids, excretions or secretions) were stacked and stored on top of each other; 3. One of one sampled staff (Housekeeper (HSK)) 1 was not wearing a face mask (a protective mask covering the nose and mouth to prevent yourself from breathing bad air or from spreading germs) when in the facility; 4. Contact tracing (is an intervention where an initial case with confirmed infection is asked to provide information about contact people who were at risk of acquiring infection from the initial case within a given time period before the positive test result), monitoring, cohorting (imposed grouping, such as health care workers, potentially exposed to designated diseases) and reporting to LHD (Local Health Department) and CDPH (California Department of Public Health) were not immediately implemented when one of 17 sampled staff, (CNA) 5, was confirmed positive for COVID-19 on 7/29/20; 5. Five of 17 sampled staff (CNA 3, CNA 4, CNA 5, CNA 6 and CNA 7) positive for COVID-19 were allowed to return to work prior to recovery. These failures resulted in 27 of 29 sampled residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, Resident 19, Resident 20, Resident 21, Resident 22, Resident 23, Resident 24, Resident 25, Resident 26, Resident 27) and 17 of 51 sampled staff (LVN 2, LVN 3, CNA 1, CNA 3, CNA 4, CNA 5, CNA 6, CNA 7, CNA 8, CNA 9, CNA 10, CNA 11, CNA 12, CNA 13, CNA 14, CNA 15, and Activity Director (AD)) in the facility testing positive for COVID-19. This had also the potential for the continued spread of COVID-19 infection to 29 residents, 51 staff and visitors. A condition of Immediate Jeopardy (IJ) was identified for the facility's failure to prevent the spread of infection when the facility failed to educate, monitor, and ensure staff were using and storing personal protective equipment (PPE-refers to equipments (N95 masks and face shield)) worn to minimize exposure to a variety of hazards, COVID-19 positive staff were allowed to return to work during their infectious period and contact tracing monitoring, cohorting and reporting requirements were not immediately implemented per CDC and facility policy. These failures resulted in continued spread of infection to 27 of 29 residents and 17 of 51 staff infected with COVID-19 and the potential for continued spread of infection to residents, staff and visitors. The IJ was called on 8/7/20 at 11:07 AM, with the Administrator and Chief Nursing Officer (CNO). The surveyors confirmed by observation, interview, and record review, on 8/7/20 that the facility had inserviced their staff on the proper storage and use of PPE and a system was put in place to monitor the staff. The COVID-19 positive staff were sent home and the LHD was contacted for guidance. The facility's plan of correction was accepted. The IJ was removed on 8/7/20, at 2:43 PM with the Administrator. Findings: 1. During an interview on 8/6/20, at 3:40 PM, with LVN/PPEC 1, LVN/PPEC 1 stated, the individual N95 masks has to be worn for 48 hours and stored in sandwich containers that were labeled day 1, day 2 and day 3. LVN/PPEC 1 was unaware how many days an N95 mask has to be worn before it is replaced. During a concurrent observation and interview on 8/6/20, at 3:55 PM, with CNA 2, in the yellow zone (designated area for residents that have been exposed to COVID-19), CNA 2 was observed wearing an N95 mask. CNA 2 stated she had been using the same mask four days in a row. CNA 2 stated No one has given me anymore. This is my fourth day to work, yes, I've used this mask four times in a row. During an interview on 8/6/20, at 3:57 PM, with LVN 1, LVN 1 stated the N95 mask should be used two to three days or until soiled. LVN 1 stated, he was unaware how many times his N95 mask had been used. During a concurrent observation and interview on 8/6/20, at 4:02 PM, with CNA 1, CNA 1 was wearing an N95 mask. CNA 1 stated she had worn the N95 mask for two consecutive days. She also stated she was not trained on how to rotate the N95 mask or how many times to wear the N95 mask before disposing it. During a concurrent observation and interview on 8/6/20, at 4:47 PM, with LVN/PPEC 2, in the red zone (COVID-19 positive designated unit), LVN/PPEC 2 was observed wearing an N95 mask. LVN/PPEC 2 stated she was provided one N95 mask and three styrofoam containers to store her mask. LVN/PPEC 2 stated the containers are dated and labeled day one, day two, day three and she rotates her one N95 mask between the three containers. LVN/PPEC 2 also stated the N95 mask she was currently wearing had also been worn on 8/4/20 and 8/5/20. She stated after three days of wearing the N 95 mask consecutively, the N95 mask and containers will be thrown away and a new N95 mask and three containers should be provided. During a concurrent interview and review of the facility training record on 8/7/20, at 9:52 AM, with the Infection Preventionist (IP- are the person who specializes in preventing infection), the IP stated, the facility had implemented extended use of N95 and each employee was given three N95 masks and three containers. The containers are labeled day 1, day 2 and day 3. Day 1 mask is worn on day 1 and stored in the day 1 container, on day 2, day 2 mask is worn and then stored in day 2 container and on day 3, day 3 mask is worn and stored in day 3 container. After using each N95 three times the masks are discarded and the employees are provided a new set of N95 mask and containers. The IP was unable to provide evidence that staff were trained on the extended use of the N95 masks. IP stated there was no lesson plan for extended use of the N95 mask and competencies had not been completed by the staff. During a review of the facility's policy and procedure (P&P) titled, COVID-19 Facility Exposure Management, undated, the P&P indicated, Employees may utilize extended use techniques with masks and eye protection when caring for residents .Staff competencies and observations of daily handwashing and PPE procedures must be completed by the facility management staff. During a review of the Centers for Disease Control and Prevention (CDC) Strategies for Optimizing the Supply of N95 Respirators updated on 4/2019, it indicated, Training on indications for use of N95 respirators-It is important that HCP (Health Care Personnel) be trained on indications for use of N95 respirators. The OSHA Respiratory Protection standard requires employers to provide respirator training to an employee prior to use in the workplace. Limited re-use of N95 respirators-One effective strategy to mitigate the contact transfer of pathogens from the respirator to the wearer could be to issue each HCP who may be exposed to COVID-19 patients a minimum of five respirators. Each respirator will be used on a particular day and stored in a breathable paper bag until the next week. This will result in each worker requiring a minimum of five N95 respirators if they put on, take off, care for them, and store them properly each day. This amount of time in between uses should exceed the 72 hour expected survival time for [DIAGNOSES REDACTED]-CoV2 (virus that caused COVID-19). HCP should still treat the respirator as though it is still contaminated. 2. During a concurrent observation and interview on 8/6/20, at 3:40 PM, with LVN/PPEC 1, in the yellow zone, there were multiple face shields stacked on top of each other on two tables near the entrance/exit of the yellow zone. LVN/PPEC 1 confirmed the findings and stated, the face shields are shared among the staff in the yellow zone. During a concurrent observation and interview on 8/6/20, at 3:55 PM,

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) with CNA 2, multiple face shields were stacked on a bed side table in the hallway in between yellow zone entrance/exit and resident room. Stacked face shields were open to air and accessible to staff and residents. CNA 2 stated all face shield were shared by all staff working in the yellow zone. CNA 2 stated face shields were sprayed with a disinfectant after each use and stacked after it was dry. During a concurrent observation and interview on 8/6/20, at 4:25 PM, with LVN/PPEC 2, in the red zone, there was a sign inside the entry/exit door of the unit on the right and left side of the hall that indicated, donning (clean area for employees to put on PPE) and a doffing (area for removal of PPE) sign on the right side of the hallway. There were several face shields stacked on top of one another on a table on the left side of the hall that contained staff names. LVN/PPEC 2 confirmed the findings and stated, the staff are to put the face shields in the doffing area and nurses are responsible to sanitize the face shields after use and place in the donning area. LVN/PPEC 2 stated, with two donning signs it was confusing to determine the clean side from the dirty side. During a concurrent observation and interview on 8/7/20, at 10 AM, with LVN/PPEC 2, two stacks of approximately 10 face shields were placed on a bed side table in the red zone hallway. Stacked face shields were open to air and accesible to staff and residents. LVN/PPEC 2 stated the face shields were shared between all positive and negative staff working in the red zone. LVN/PPEC 2 stated, Each staff is responsible to spray a disinfectant on their own face shield after each use and after it's dry (sic). I stack them on the clean side. During a review of the Centers for Disease Control and Prevention (CDC) Operational Considerations for Personal Protective Equipment in the Context of Global Supply Shortages for Coronavirus Disease 2019 (COVID-19) Pandemic: non-US Healthcare Settings updated 5/5/20, it indicated, Reuse: A. Reprocessing and reusing disposable face shields for one HCW (Healthcare Worker) to use on multiple patients with COVID-19 for a limited time-period (multiple shifts). This strategy is not consistent with best practices and therefore not recommended, but if adopted: A face shield should be dedicated to one HCW. They should be immediately reprocessed when they are visibly soiled, whenever they are removed such as when leaving the isolation area, and at least daily (after every shift) prior to putting them back on (See reprocessing guidance below). After reprocessing, a face shield should be stored in a transparent plastic container and labeled with the HCW name to prevent accidental sharing between HCW. 3. During a concurrent observation and interview on 8/6/20, at 3:28 PM, with HSK 1, outside the laundry room, HSK 1 went to the dining room with N95 mask on. It was noted she was no longer wearing an N95 mask or facial mask when she went back to the laundry room to gather her personal belongings. She spoke with two other laundry staff who were less than six feet from her. HSK 1 confirmed the findings and stated a facial mask has to be worn when inside the facility. During an interview on 8/6/20, at 3:40 PM, with LVN/PPEC 1, LVN/PPEC 1 stated, The staff should have a facial mask on after removing their N95 mask . During an interview on 8/6/20, at 5:05 PM, with the CNO, the CNO stated when staff are in the facility they are expected to wear a facial mask. During a review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 7/15/20, it indicated HCP should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. 4. During a concurrent observation and interview on 8/7/20, at 10:05 AM, with CNA 5, in the red zone, CNA 5 stated she had gone to her own clinic to get tested for COVID-19 on 7/28/20, and had received her positive test result on 7/29/20. CNA 5 stated she developed COVID-19 symptoms including a runny nose on the day she tested (7/28/20), a sore throat three days after being tested (7/31/20), and a headache two days ago (8/5/20). CNA 5 stated she notified the Assistant Administrator (AA) of her positive test result on 7/29/20 and was notified by AA on 8/6/20 to return to work on 8/7/20. During an interview on 8/7/20, at 10:05 AM, with IP, IP stated she was aware CNA 5 had tested positive for COVID-19 on 7/29/20. IP stated she did not notify LHD of CNA 5's positive test result. During an interview, on 8/7/20, at 10:41 AM, with AA, AA stated CNA 5's husband had been exposed to COVID-19 and CNA 5 had decided to get tested on her own. AA stated CNA 5 was confirmed positive for COVID-19 on 7/29/20. AA stated CNA 5 was a part time employee of the facility and was not required to notify LHD or CDPH of CNA 5's confirmed positive test result. AA stated, Why should I she's (CNA 5) not an employee. She's not full time, she's only part time. AA reviewed the facility Daily Assignment Sign-In Sheet and confirm CNA 5 had worked on 7/28/20. AA stated she did not implement contact tracing, cohorting and/or monitoring to any exposed residents and staff after CNA 5 was confirmed positive of COVID-19. During an interview on 8/7/20, at 11:07 AM, with the CNO, the CNO stated, when CNA 5 tested positive for COVID-19 on 7/29/20, response-driven testing (contact tracing and testing in response to an outbreak) should have been implemented. During an interview, on 8/7/20, at 2:31 PM, with the Local Health Department Physician (LHDP), LHDP stated she was not informed of CNA 5 being positive on 7/29/20. LHDP stated it is the responsibility of the facility to notify LHD of any new COVID-19 positive residents and staff and all exposed residents and staff. LHDP stated contact tracing should have been implemented immediately. During an interview on 8/7/20, at 11:08 AM, with the Administrator, the Administrator was unaware CNA 5 had tested positive for COVID-19. During a review of the facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19) Prevention and Control, undated, the P&P indicated, The Infection Preventionist is responsible for establishing and overseeing the active surveillance and monitoring efforts including: Immediately reporting new cases of suspected or confirmed COVID-19 to the local health department. During a review of the Centers for Disease Control and Prevention guideline titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 6/19/20, it indicated, Healthcare facilities should have a process for notifying the health department about suspected or confirmed cases of [DIAGNOSES REDACTED]-CoV-2 Infection, and should establish a plan, in consultant with local public health authorities, for how exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. During a review of the Centers for Disease Control and Prevention (CDC) Testing Guidelines for Nursing Homes Testing Individuals updated on 7/21/2019, it indicated, Perform expanded [MEDICAL CONDITION] testing of all residents in the nursing home if there is an outbreak in the facility .A single new case of [DIAGNOSES REDACTED]-CoV-2 (COVID-19) infection in any HCP or a nursing home-onset [DIAGNOSES REDACTED]-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected with [DIAGNOSES REDACTED]-CoV-2 who can continue to spread the infection, even if they are asymptomatic. Performing [MEDICAL CONDITION] testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC (Infection Prevention and Control) (e.g., isolation, cohorting, use of personal protective equipment) to prevent [DIAGNOSES REDACTED]-CoV-2 transmission. During a review of the facility's policy and procedure (P&P) titled, COVID-19 Facility Exposure Management, undated, the P&P indicated, Facilities .Should communicate with physician, local health department, regulatory agency, families, staff and residents .The management staff must maintain a line listing of all staff who work in other health care settings. It must be communicated to each staff member to self-report any exposure they may have had offsite. 5. During an interview on 8/6/20, at 8:49 AM, with the AA, the AA stated, between 8/3/20 and 8/5/20, there were five nursing staff (CNA 3, CNA 4, CNA 5, CNA 6 and CNA 7) who tested positive for COVID-19, and continued to work in the red zone between 8/3/20 to 8/7/20. During an interview on 8/6/20, at 10:22 AM, with the AA, the AA stated, the facility would not be able to meet staffing needs if the COVID-19 positive staff were not working. AA stated, the facility had not used staffing registries nor had they changed the staff to 12 hour shifts to decrease the amount of employees needed to meet staffing needs. AA confirmed facility had not implemented it's own policy to address staffing shortage including contingency strategies. During a concurrent observation and interview on 8/6/20, at 2:03 PM, with CNA 3, in the red zone, CNA 3 stated she was tested for COVID-19 on 8/3/20, was notified by Director of Nursing (DON) of her positive test result on the evening of 8/4/20 and had returned to work on 8/6/20. CNA 3 stated, I was told to come to work if I was asymptomatic. During a concurrent observation and interview on 8/6/20, at 4:52 PM, with CNA 4, in the red zone, CNA 4 stated she was tested for COVID-19 on 8/3/20 and was reassigned to work from the yellow zone to the red zone after she was notified of her positive result on 8/4/20 . CNA 4 stated, I was actually working in the yellow zone, (AA) told me to get out of the yellow zone and go to red zone. During a concurrent observation and interview on 8/7/20, at 10:05 AM, with CNA 5, in the red zone, CNA 5 stated she had gone to her own clinic to get tested for COVID-19 on 7/28/20, and had received her positive test result on 7/29/20. CNA 5 stated she developed COVID-19 symptoms including a runny nose on the day she tested (7/28/20), a sore throat three days after being tested (7/31/20), and a headache two days ago (8/5/20). CNA 5 stated she was notified by AA to return to work on 8/7/20. CNA 5 stated she was never cleared by LHD to return to work on 8/7/20. CNA 5 stated, AA just told me to come back to work if I didn't have a fever. CNA 5 confirmed she never developed a fever but developed other COVID-19 symptoms including the sore throat and headache. During an interview on

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) 8/7/20, at 10:05 AM, with IP, IP stated she was aware CNA 5 was tested positive for COVID-19 on 7/29/20. IP stated based on symptoms, CNA 5 was cleared by the AA to return back to work 8/7/20. IP confirmed CNA 5 had worked in the red zone on 8/7/20. During an interview, on 8/7/20, at 10:41 AM, with AA, AA stated CNA 5 last worked on the floor on 7/28/20. AA stated CNA 5's husband was exposed to COVID-19 and decided to get tested on her own. AA stated CNA 5 was positive of COVID-19 on 7/29/20. AA stated she determined CNA 5 can return back to work 8/7/20 when CNA 5 reported having a fever and/or taking any fever reducing agent within the last 24 hours. AA stated she did not notify LHD for guidance on CNA 5 returning back to work 8/7/20. AA stated, I told her she can come back to work. During an interview on 8/7/20, at 2:31 PM, with the LHDP, the LHDP stated, CNA 5 should not return to work until after at least 10 days have passed from the onset of COVID-19 symptoms. LHDP stated, if the facility was in a staffing crisis and had tried all other avenues and solutions to meet staffing needs, CNA 5 could return to work prior to the 10 days. LHDP stated, guidance was not given to the facility for CNA 5 to return to work prior to the 10 day period. During a review of the facility's approved COVID 19 Mitigation Plan (MP), undated, the MP indicated, Facility will ensure IP reviews guidance and recommendations provided by CDC, CDPH, and/or LHD to maintain consistent situational awareness with highly evolving nature of COVID. During a review of the facility's policy and procedure (P&P) titled, Planning for Additional Staffing Needs undated, the P&P indicated, When staffing shortage are anticipated, the facility, should use contingency capacity strategies to plan and prepare for mitigating this problem. The facility will adjust staff schedules, hire additional HCP, and rotate HCP to positions that support patient care activities as appropriate.