STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055809	A. BUILDING _____ B. WING _____	**07/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST ANTHONY CARE CENTER	**553 SMALLEY AVENUE HAYWARD, CA 94541**

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 accepted national standards (Centers for Disease Control - CDC) for infection control practices to prevent spread of infection in the facility during a novel Coronavirus Disease (COVID 19- a mild to severe respiratory (lung) illness) outbreak (an occurrence of disease greater than expected at a particular time and place) when: 1. The facility failed to ensure all staff were screened for COVID-19 symptoms before entering the building, and five of 22 screened employees/visitors had no documented screening for COVID-19 symptoms. 2. The door was kept open to one of two rooms with PUI (Persons under Investigation for COVID-19 infection) residents (Residents 1 and Resident 2). 3. Face shields for staff use during resident care provision were stored in a room occupied by a PUI resident (Resident 3). These failures had the potential to result in spread of COVID-19 among residents and staff. Findings: 1. During an observation on 7/28/20, at 9:35 a.m., the facility had two employee entrances. Entrance 1 had a screening station with a table. On top of the table was a binder labeled, Visitor/ Employee Symptom Screening Log, a thermometer, and a container of disinfecting wipes. Entrance 2 was accessed from the facility parking lot ; there was no screening station. The direct path from Entrance 2 to Entrance 1 passed the doorways of resident Rooms 7, 8, 9, 10, 11, and 12. During an interview on 7/28/20, at 11:30 a.m., with the Director of Nursing (DON) and Licensed Vocational Nurse 2 (LVN 2), the DON stated staff used both Entrance 1 and 2 to enter the facility. DON stated employees were screened for COVID-19 symptoms only at Entrance 1. During a review of the facility document titled, Visitor/ Employee Symptom Screening Log dated 7/28/20, the Log had columns for data entry that included: time of entry, name of entrant, temperature, and Have a new onset of the following: . cough, shortness of breath, difficulty breathing, runny nose, sore throat, fatigue, muscle/body ache or headaches, chills, new loss of taste or smell, nausea or vomiting, diarrhea. Each listed New Onset symptom had two columns to indicate presence (Y), or absence (N) of the symptom. The Log indicated, Instructions: check either Y or N column of each symptom according to the response. The Instructions also indicated a yes response to any of the listed symptoms would result in denial of entry into the facility. During a review of the facility, Visitor/ Employee Symptom Screening Log, dated 7/28/20, the Log indicated five of 22 screened staff (Cook 1, Cook 2, Housekeeper 1, Certified Nursing Assistant 3, and Certified Nursing Assistant 4) had no entries in the columns for Have a new onset of the following. During a review of CDC article titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 6/15/20, the article indicated, Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19 .Limit and monitor points of entry to the facility .Screen everyone (patients, HCP, visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with [DIAGNOSES REDACTED]-CoV-2 (also known as COVID-19) infection .Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature greater than 100.0F or subjective fever 2. During an interview on 7/28/20, at 9:35 a.m., with the DON, the DON stated Resident 1 shared a room with Resident 2, and both residents had been admitted within the last two weeks. The DON stated, as new admissions, the residents were PUI, and so were under observation for COVID-19 infection for two weeks following admission. During an observation on 7/28/20, at 9:47 a.m., the door to Resident 1 and 2's shared bedroom was open. During an interview on 7/28/20, at 9:55 a.m., Housekeeper (HSKP 1) stated she had just cleaned Resident 1 and 2's bedroom, but the door was always left open. During an interview on 7/28/20, at 11:30 a.m., DON stated Resident 1 and 2's bedroom room should be kept closed. During a review of the Center for Disease Control article, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/15/2020, the article indicated, place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 (COVID-19) infection in a single-person room with the door closed. 3. During a concurrent observation and interview on 7/28/20, from 11:51 a.m. to 12:03 p.m., CNA 2 entered a PUI resident's room (Resident 3), without wearing a face shield (a type of PPE, a plastic shield that protects the face from respiratory secretions and droplets). Inside Resident 3's room, CNA 2 wore a face shield while she checked Resident 3's temperature, heart rate, and respiratory rate. CNA 2 exited Resident 3's room without a face shield on. CNA 2 stated she stored her face shield on a table inside Resident 3's room. During an interview on 7/28/20, at 12:07 p.m., with ADM and CNA 2, CNA 2 stated there were five or six face shields stored on a table in Resident 3's room. ADM stated staff had been instructed to store their face shields in Resident 3's room, when there was no resident staying in that room, but that the room occupied by a PUI resident should not have face shields stored inside the room. ADM stated he had not known direct care staff continued to store face shields in the room after Resident 3 was admitted to that room. During a review of the Center for Disease Control article, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated 7/15/2020, the article indicated, Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area .Remove eye protection after leaving the patient room or care area

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.