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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 056324 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 09/03/2020 |
| NAME OF PROVIDER OF SUPPLIER WINDSOR HAMPTON CARE CENTER | | STREET ADDRESS, CITY, STATE, ZIP 442 HAMPTON STREET STOCKTON, CA 95204 | |
| 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. Based on observation, interview, and record review, the facility failed to implement infection prevention and control measures to prevent the spread of COVID-19 when every person entering the facility was not screened for all symptoms of COVID-19. This failure placed residents at risk of contracting COVID-19, with the potential of causing illness or death. During an observation on 8/26/20, at 11:55 a.m., the Receptionist screened the Department only for COVID-19 symptoms of fever, cough, shortness of breath and sore throat upon entry to the facility. The facility did not screen the Department for all symptoms of COVID-19 which include fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. Review of the untitled, undated facility document used on 8/26/20, to screen visitors for symptoms of COVID-19 indicated visitors should report symptoms of fever, cough, shortness of breath and sore throat. The document did not list all symptoms of COVID-19 which included fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea. During an interview with Infection Preventionist (IP) on 8/26/20, at 2:25 p.m., IP stated they have an updated COVID-19 symptoms questionnaire (a set of written or printed questions for the purpose of gathering information from respondents) for visitors and vendors but used the old COVID-19 questionnaire today. The IP stated the facility should use the updated COVID-19 questionnaire. According to Centers for Disease Control and Prevention (CDC), Symptoms of Coronavirus, dated 5/13/20, People with these symptoms may have COVID-19: Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea . https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html Review of CDC, Preparing for COVID-19 in Nursing Homes, dated 6/25/2020, indicated, Screen visitors for fever ., symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html) | | |
| 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.