STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055735	A. BUILDING _____ B. WING _____	09/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR ELMHAVEN CARE CENTER	**6940 PACIFIC AVENUE STOCKTON, CA 95207**

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 implement infection prevention and control measures to prevent the spread of COVID-19 when: 1. Facility employees and visitors entering the facility were screened for COVID-19 with a thermometer that was not working, 2. Facility employees did not sanitize their hands before putting on Personal Protective Equipment (PPE) (special equipment such as facemask, faceshield, gown and gloves worn by healthcare providers to help prevent the spread of germs). These failures placed residents at risk of contracting COVID-19, with the potential of causing illness or death. Findings: 1. During a concurrent observation and interview on 8/25/20, at 9:20 a.m., Certified Nursing Assistant (CNA) 1 checked facility employees' and visitors' temperature upon entrance to the facility. CNA 1 notified them of their temperature readings between 95 and 96 degrees Fahrenheit (F). CNA 1 stated, .Everyone's (temperature) reading is low today . CNA 1 indicated a temperature below 97F was low and the thermometer was not working properly. CNA 1 indicated there were many people to screen and she was not able to leave to find a new thermometer. CNA 1 confirmed the screening for fever with a thermometer that was not working, was not performed correctly. CNA 1 stated all temperature readings during the morning may have been wrong and someone may have had a temperature of 99F or higher. CNA 1 further stated anyone with temperature 99F or higher was not allowed to enter the facility. During an interview with the Infection Preventionist (IP) on 8/25/20, at 11:30 a.m., the IP stated if a thermometer reads a temperature less than 97F then its not working and should be changed. The IP further stated staff and visitors need to wait until screened accurately with a working themometer. The IP stated if temperature readings are 95F or 96F then there is potential that temperature screening was inaccurate. During an interview with Director of Nursing (DON) on 8/25/20, at 1:10 p.m., the DON stated a thermometer reading temperatures of 95 to 96 F is not acceptable. The DON confirmed screening for all persons with temperature readings of 95 to 96F was not accurate. The DON further stated their temperature should have been rechecked before they were let further into the facility. The DON stated CNA 1 should have them wait and get another thermometer to recheck the temperature accurately and then could have allowed them to enter the facility. During a review of untitled facility documents the facility used to log employees' screening for fever and COVID-19 symptoms, dated 8/25/20, indicated, 57 employees' temperature readings were documented 94, 95 and 96F. During a review of an undated facility document titled,(Facility Name) COVID-19 Mitigation Plan, indicated,IP (Infection Preventionist) is responsible for overseeing screening of all individuals entering the facility to include temperature and other signs and symptoms of COVID-19 . During a review of the facility document, provided by the Administrator (ADM) that facility follows for screening of employees and visitors upon entrance to the facility, titled,San Joaquin County Public Health Services dated 5/27/20, indicated, .SNF (skilled nursing facility) is to have an active screening process of all staff at the beginning of their shifts to ensure no one is working who may be sick. The screening is to include checking for fever According to Centers for Disease Control and Prevention (CDC), Preparing for COVID-19 in Nursing Homes, dated 6/25/20, indicated,Screen all HCP (Health Care Providers) at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature . If they are ill, have them .leave the workplace.*Fever is either measured temperature >100.0 F or subjective fever Clinical judgement should be used to guide testing of individuals . https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html 2. During an interview with the DON on 8/25/20, at 8:25a.m., the DON stated facility staff reused N-95 facemasks(a mask which filters 95% of small particles in the air and is recommended for protection from COVID-19). During a concurrent observation and interview on 8/25/20, at 8:40 a.m., the Activity Assistant (AA) did not sanitize his hands after removing his surgical facemask and before putting on the N-95 facemask and faceshield at the beginning of his shift. The AA confirmed he did not sanitize his hands today, when he removed his surgical facemask and put on his N-95 facemask and faceshield. The AA stated he should sanitize his hands before he put on any PPE and after he removed PPE. During a concurrent observation and interview on 8/25/20, at 9 a.m., the Staffing Coordinator (SC) did not sanitize her hands after she removed her cloth facemask and before putting on her N-95 facemask at the beginning of her shift. The SC confirmed she did not sanitize her hands after she removed her cloth facemask and before she put on the N-95. The AA stated she should wash her hands before and after she touched the PPE. During a concurrent observation and interview on 8/25/20, at 9:15 a.m., the Business Development (BD) did not sanitize her hands before she put on her N-95 facemask and goggles. The BD confirmed she did not sanitize her hands before she put on her N-95 facemask and goggles and stated she should sanitize her hands before she put on PPE. During an interview with the DON on 8/25/20, at 1:10 p.m., the DON stated staff should perform hand hygiene before they put on PPE and after they remove PPE. According to Centers for Disease Control and Prevention (CDC), Using Personal Protective Equipment (PPE), dated 8/19/20, indicated, How to Put On (Don) PPE Gear .Identify and gather the proper PPE to don .Perform hand hygiene using hand sanitizer .Put on NIOSH-approved N95 filtering facepiece respirator Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is [MEDICATION NAME] reuse. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.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.