STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555336	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINGSTON HEALTHCARE CENTER, LLC	**329 REAL ROAD BAKERSFIELD, CA 93309**

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 -** 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 ensure infection prevention practices were in place to prevent the spread of infection for residents who utilize the smoking patios. The findings included: Co-mingling residents negative for Coronavirus (COVID 19 is an illness caused by [MEDICAL CONDITION] that can spread from person to person) (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, and Resident 8) with residents under investigation for COVID 19 (Resident 6 and Resident 7), Facility staff not performing hand hygiene (cleaning hands to remove germs) between resident contact, and Facility staff not sanitizing shared smoking aprons between resident use. This failure had the potential to spread COVID 19 to all (126) residents and facility staff. Findings: During an interview on 5/3/20, at 11:14 AM, with Infection Preventionist (IP person who specializes in preventing infections), and the facility's Registered Nurse Consultant (RNC), IP and RNC stated a certified nurse assistant (CNA) is assigned to the smoking patios. The CNA is to ensure residents from A wing (residents negative for COVID 19) were separate from B wing residents (persons under investigation (PUI) for COVID 19 due to exposure or exhibiting signs and symptoms), and B wing residents from C wing residents (residents positive COVID 19). During an observation on 5/3/20, at 11:36 AM, on the B wing smoking patio, eight residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, and Resident 8) were observed without masks and not social distancing on the patio. CNA 1 entered the patio with a blue lock box. CNA 1 was wearing gloves, gown, mask, and a face shield. CNA 1 use the keys from the lock box to unlock individual lockers on the patio and pass out residents' personal supplies of cigarettes. Resident 5 (negative for COVID) placed smoking aprons on several residents including Resident 6 (PUI). CNA 1 did not perform hand hygiene between handling personal supply of cigarettes and lighting each residents' cigarette. During a concurrent interview and record review on 5/3/20, at 11:36 AM, of the facility census (facility document that contains names and room numbers of residents in the facility) and facility map of COVID 19 quarantine areas (A wing -residents negative for COVID 19, B wing -residents under investigation for COVID 19 due to exposure or exhibiting signs and symptoms, and C wing -residents positive COVID), and interview with eight residents confirmed the following: Resident 1 A wing negative Resident 2 A wing negative Resident 3 A wing negative Resident 4 A wing negative Resident 5 A wing negative Resident 6 B wing PUI Resident 7 B wing PUI Resident 8 A wing negative During an interview on 5/3/20, at 11:46 AM, with CNA 1, CNA 1 stated he had not received any education on the duties or expectations on the smoking patio. CNA 1 stated the facility did not educate him on performing hand hygiene between each resident contact on the smoking patio or disinfecting smoking aprons after use. CNA 1 stated he was not privy to what residents were infected or under investigation for COVID 19. CNA 1 stated, Anyone who is suspected should not be allowed out here. CNA 1 stated, I assumed anyone out here would not be suspected. During an observation and interview on 5/3/20, at 12:05 PM, with IP and RNC, IP and RNC were informed of the immediate jeopardy (IJ) findings on B wing smoking patio. The lack of: staff, barriers to prevent resident from co-mingling, hand hygiene by staff and of hand hygiene supplies, supplies available for disinfecting smoking aprons between resident use, all which had the potential for the spread of COVID 19. IP and RNC observed the B wing-smoking patio. IP and RNC confirmed three was no staff present on the patio, no barrier between A wing and B wing, no hand hygiene station or hand sanitizer available for staff or resident use, one hand sanitizer dispenser was found empty, and no system or supplies available to sanitize smoking aprons after each resident use. IP and RNC confirmed the findings and agreed it was an infection control breech. IP and RNC stated the plan of correction was to assign and educate staff for both A wing and B wing smoking patios. Place barriers with yellow caution tape to separate A wing from B wing and C wing from B wing. Ensure hand sanitizer and bleach wipes were available at both smoking patios for hand hygiene and apron disinfection. IP and RNC were informed all the corrections must be in place on both A wing and B wing smoking patios before the IJ could be removed. During an observation on 5/3/20, 1:48 PM, with IP and RNC on the A wing smoking patio, no staff or residents were present, no hand sanitizer, no bleach wipes, or barriers were in place to ensure proper infection control practices for the facility's residents and staff. During a review of the facility Line List (a line list is a table that contains key information about each case in an outbreak that includes basic resident information to identify cluster outbreaks and infection patterns), dated 7/15/20, the Line List indicated the following: Resident 1 tested positive for COVID 19 on 5/6/20 Resident 2 tested positive for COVID 19 on 5/6/20 Resident 4 tested positive for COVID 19 on 5/7/20 Resident 5 tested positive for COVID 19 on 5/7/20 Resident 8 tested positive for COVID 19 on 5/5/20

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.