STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555692	A. BUILDING _____ B. WING _____	08/31/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PLYMOUTH SQUARE	1319 N. MADISON STREET STOCKTON, CA 95202

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, record review, and facility policy review, the facility failed to ensure infection from COVID-19 (a disease caused by [MEDICAL CONDITION] which can result in severe illness and death) was identified and prevented from spreading, for a census of 25, when; 1. Resident 4 was exposed to a COVID-19 positive roommate and not placed on transmission based precautions (measures taken to prevent the spread of germs which can cause disease) and no isolation signage was posted at Resident 4's door; 2. Resident 1 was admitted within the 14-day incubation period for COVID-19 (the time [MEDICAL CONDITION] takes to infect someone after exposure) and was not placed on isolation precautions on admission, or after Resident 1 developed symptoms suggestive of COVID-19. There was no signage posted at Resident 1's door; 3. Staff assisted Resident 3 with dinner, without removing all prior PPE and cleaning hands; 4. Staff did not monitor Resident 1 for symptoms of COVID-19 per facility policy, to allow prompt detection of change in condition or infection, including oxygen saturation levels (indicates the amount of oxygen circulating in blood) and respiratory rate (the amount of breaths per minute); 5. Resident 4 was placed into a room in the COVID-19 unit (space designated for COVID-19 positive residents to limit exposure to residents not infected with COVID-19) when she had symptoms suggestive of infection but did not have a positive COVID-19 test; and, 6. Staff were scheduled to work with residents infected with COVID-19 and with non-infected residents during the same shift. These failures placed residents and staff at risk of exposure and spread of infection with a possibility of severe illness or death from COVID-19. Findings: 1. Review of a facility list of residents with positive COVID-19 indicated Resident 5 was confirmed positive for COVID-19 on 7/6/20, at the general acute care hospital (GACH). The document indicated, .Pt. (Resident 5) was transferred out to acute care setting. Roommate (sic) (Resident 4) is being placed on isolation as PUI (person under investigation) . During an observation on 7/15/20, at 12:15 p.m., Resident 4's doorway had no signage posted to alert staff she was on isolation and the type of personal protective equipment (PPE) required during care. Certified Nurses Assistant (CNA) 3 exited Resident 4's room and entered room [ROOM NUMBER] without removing and replacing her gown. During an interview on 7/15/20, at 12:24 p.m., CNA 3 stated, .I don't use special PPE. She (Resident 4) does have a cough. They (leadership) said as long as they're on this side it's not necessary . Review of the Centers for Disease Control and Prevention (CDC) Preparing for COVID-19 in Nursing Homes updated 6/25/20, indicated, .Residents in the facility who develop symptoms consistent with COVID-19 .HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection .gloves, and gown when caring for these residents. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html. Review of the facility document, Coronavirus Disease 2019 (COVID-19) Mitigation Plan for Skilled Nursing Facilities undated, indicated, .Signs are posted immediately outside of resident rooms indicating appropriate infection control and prevention precautions and required PPE . 2. During an interview on 7/15/20, at 12:30 p.m., with the director of nursing (DON), the DON stated, .They (Resident 1 and Resident 2) were negative (for COVID-19) on discharge from the hospital. (Resident 1) got here on (7/9/20) and his roommate (Resident 2) maybe over two weeks . The DON indicated she was unaware residents should be treated with precautions for 14 days during the incubation period of [MEDICAL CONDITION]. During an interview on 7/15/20, at 1:05 p.m., the infection preventionsist (IP) indicated residents admitted from the hospital who required 14-day observation did not need to be treated with precautions if they were tested for COVID-19 before coming to the facility. During a concurrent interview and record review on 7/15/20, at 3:55 p.m., with the assistant director of nurses (ADON), the ADON reviewed Resident 1's clinical record and stated, .Yes, he (Resident 1) had a temperature of 100 on 7/14/20 .No precautions as chest x-ray was negative and the result (for COVID-19) at hospital was negative (from 7/9/20). We let (IP) know and he would tell us to isolate . The ADON indicated she was aware a person could show symptoms of COVID-19 during the 14-day time period after exposure. Review of the facility policy, COVID-19 Cohorting procedures dated 5/27/20, indicated, .Upon admission, new and readmitted residents with unknown COVID-19 status are placed in single occupancy rooms or a separate observation unit or wing . Review of the Centers for Disease Control and Prevention (CDC) Responding to Coronavirus (COVID-19) in Nursing Homes updated 4/30/20, indicated, .Testing residents upon admission could identify those who are infected .However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) 3. During an observation on 7/15/20, at 5:44 p.m., Certified Nurses Assistant (CNA) 4 walked through the plastic partition from the COVID-19 unit into the non COVID-19 unit carrying meal trays to the dining cart CNA 4 wore a mask, face shield, and had gloves on. CNA 4 removed his gloves. He did not remove his face shield and did not clean his hands. CNA 4 entered Resident 3's room in the non-COVID-19 unit and said, .ready to eat? . CNA 4 placed a clothing protector across Resident 3's chest, unwrapped her meal and sat next to the bed to assist her. During an interview on 7/15/20, at 6:05 p.m., CNA 4 stated, .I guess I forgot to wash my hands . coming out of there (the COVID-19 unit) I'm supposed to take off my PPE . During a concurrent observation and interview on 7/15/20, at 6:20 p.m., LN 4 came into the non COVID-19 unit from the COVID-19 unit. LN 4 indicated staff must remove PPE and clean their hands before coming to the non COVID-19 unit. LN 4 stated, .We don't want these other residents to get sick . Review of the facility policy, Handwashing/Hand Hygiene revised August 2015, indicated, .The facility considers hand hygiene the primary means to prevent the spread of infections .Use an alcohol-based hand rub .or .soap .and water for the following situations .Before and after direct contact with residents .After removing gloves .Before and after entering isolation precaution settings . 4. Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. During an observation on 7/15/20, at 10:22 a.m., Resident 1 was observed in bed, in room [ROOM NUMBER]A. Resident 1's respiratory rate, counted by the Department, was 35 breaths per minute. Normal respirations occur 12-18 times per minute. During an observation on 7/15/20, at 11:02 a.m., Resident 1 was taken out of the facility by emergency transport. Review of the clinical record, NURSE'S NOTES dated 7/9/20, at 2:50 p.m., indicated, .Resident was admitted today from (local hospital) .No SOB (shortness of breath) noted, (oxygen saturation) @ 95% . There was no documented evidence in the clinical record Resident 1's condition was monitored during the day shift on 7/11/20, day shift on 7/12/20, and the evening shift on 7/12/20. Review of the clinical record, HISTORY AND PHYSICAL dated 7/14/20, completed by Resident 1's physician, indicated, .Fever .Temp 100 . Resident 1's physician ordered a chest x-ray. Review of the clinical record, NURSE'S NOTES dated 7/15/20, at 10:10 a.m., indicated, .Lungs auscultated (listened) .and notes with crackles (an abnormal lung sound) .Cough .dizziness . A subsequent note at 10:45 a.m. indicated the LN called 911 for transport of Resident 1 to the hospital. During a concurrent interview and record review on 7/15/20, at 4:10 p.m., the ADON reviewed Resident 1's clinical record and vital sign flow sheet. The ADON indicated Resident 1 was not under observation for COVID-19 due to his negative test at the hospital and as a result he was only required to be monitored daily. The ADON confirmed Resident 1's condition changed on 7/14/20, and his symptoms could have been related to COVID-19. Review of the facility policy, COVID-19-Testing dated 5/27/20, indicated, .All residents are screened for symptoms of COVID-19 .at a minimum of two times per day and documented

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) in the clinical record 5. Review of the clinical record indicated Resident 4 was transferred to room [ROOM NUMBER]A (in the COVID-19 unit) on 7/12/20, with symptoms suggestive of COVID-19. During an interview on 7/15/20, at 12:30 p.m., with the director of nursing (DON), the DON stated, .We moved her because of coughing .We isolated her there and brought her back . The DON indicated Resident 4's COVID-19 test was negative on 7/13/20, and she was moved back into her prior room. The DON stated, .It would be hard to use that many gowns in a shift (if Resident 4 had remained in her room) .We'll run out of stuff . Review of the Centers for Disease Control and Prevention (CDC) Responding to Coronavirus (COVID-19) in Nursing Homes updated 4/30/20, indicated, .Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit) . https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) 6. During a concurrent observation and interview on 7/15/20, at 11:30 a.m., Licensed Nurse (LN) 1 passed meal trays through a plastic partition to a staff member on the other side, on the COVID-19 unit. When asked if there was a nurse in the COVID-19 unit, LN 1 stated, .No, when I finish, I'm going over there. I did a.m.(morning) meds (medications) over there (COVID-19 unit) .There should be a separate nurse in there . During a concurrent interview and record review on 7/15/20, at 4:55 p.m., the assistant director of nursing (ADON) reviewed the schedule for the evening shift and indicated, .(Certified Nursing Assistant (CNA) 4) is working COVID (19) area .He is working non COVID (19) too. (LN 3) is working all of North . The ADON confirmed the North wing contained the COVID-19 unit and rooms with non COVID-19 residents. During an interview on 7/15/20, at 6:05 p.m., CNA 4 indicated he worked on both the COVID-19 and non COVID-19 unit and stated, .I always work both . During a telephone interview on 7/16/20, at 4:30 p.m., the local public health (LPH) indicated the facility was instructed to have dedicated staff for the residents in the COVID-19 unit in order to prevent spread of COVID-19 to other residents in the facility. Review of the facility policy, COVID-19-Testing dated 5/27/20, indicated, .The COVID-19 positive cohort (group) should be housed in a separate area .of the facility and have dedicated HCP (health care personnel) who do not provide care for residents in other cohorts . Review of the facility policy, Space designation and use dated 5/27/20, indicated, .Infected residents will be separated into the designated Mitigation Unit with dedicated staff assigned separate to non COVID 19 area per shift . Review of the facility document, Coronavirus Disease 2019 (COVID-19) Mitigation Plan for Skilled Nursing Facilities undated, indicated, .The SNF (skilled nursing facility) has implemented a staffing plan to limit transmission, including: Dedicated, consistent staffing teams who directly interact with residents that are COVID-19 positive .There should be no rotation of staff between floors or wings during the period they are working each day .If these measures cannot be met the SNF will work with their LHD (local health department) .to evacuate all positive residents .