| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 05A021 | A. BUILDING _____ B. WING _____ | 08/19/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **BETHEL LUTHERAN HOME** | **2280 DOCKERY AVENUE SELMA, CA 93662** |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, record review and interview, the facility failed to ensure that the infection prevention and control program designed to provide a safe and sanitary environment was followed. Specifically, the facility failed to ensure staff members Licensed Nurse (LN) 1 and Staff 3 performed hand hygiene, doffed (removed) Personal Protective Equipment (PPE), and disinfected reusable medical devices in accordance with accepted standards of practice to prevent the spread of COVID-19. These failures placed other residents and staff at risk for potential facility-transmission of COVID-19 illness. Findings:<br>During the Entrance Conference on 08/17/2020 at 02:30 PM, the Director of Nursing (DON) stated that the facility was responding to a recent outbreak of COVID-19. She explained that the all residents in the facility had been placed under transmission based precautions for COVID-19 in either a Red Zone if they tested positive for COVID-19, or a Yellow Zone for unknown COVID-19 status. The facility consisted of three wings, A wing, B wing, and C wing. The B and C wings were designated Yellow Zones and the A wing was the Red Zone. All wings utilized closed doorways as their barrier between isolation and non-isolation areas. She further described that strategies to extend limited personal protective equipment (PPE) had been implemented for gowns, masks, respirators, and eye protection. She described that PPE could be worn in an extended capacity in the zone to care for residents with hand hygiene between, unless they are going from a resident with symptoms to a resident without symptoms. Gowns are washable, or disposable, and staff disinfect eye protection after use.<br>Observed LN1 on 07/18/2020 at 3:30 PM prepare to enter the C wing Yellow Zone. LN1 was standing in the nurses' station just outside the doors to the Yellow Unit and wore an isolation gown, a respirator covering her nose and mouth, and a face mask positioned under her chin. She donned a face shield and a pair of gloves, then pushed the medication cart through the double doors on the unit. After preparing and administering a medication to Resident 4, LN1 returned to the medication cart and set a box labeled Tears on top of it. She then removed the glove from her left hand, used the keys hanging around her neck and unlocked the cart. She opened a drawer, and replaced the box of Tears with her gloved right hand. She then doffed the right glove and performed hand hygiene at 03:36 PM. LN1 did not place the box of tears on a barrier on the med cart, and did not perform hand hygiene after removing her left glove. LN1 then stated that she had additional care to provide Resident 4. She donned (put on) a new pair of gloves and removed a glucometer, a lancet (a fine, sharply pointed needle used to prick the skin), a bottle of test strips for the glucometer and a tissue. She re-entered Resident 4's room and placed the items on a tissue barrier on the over-bed table. Observed LN1 perform the finger stick and blood glucose reading before returning to the cart. Upon returning to the cart, LN1 removed a single glove and discarded it. She did not perform hand hygiene after removing the glove. She removed a glove from a box with her ungloved hand and donned it. She then took a disinfectant wipe and wiped off the bottle of test strips, wrapped the bottle in the wipe and let it sit for 30 seconds. She then used the wipe to wipe off the glucometer, fanned the glucometer in the air and then replaced it in the cart. LN1 did not leave the glucometer to dwell in the disinfectant. LN1 then removed a single glove and typed on the computer. She did not perform hand hygiene after removal of glove. Observed LN1 prepare insulin for Resident 4 at 03:40 PM. After administering the insulin, she returned to the medication cart, removed and discarded the insulin needle and a single glove. She did not perform hand hygiene after removing the glove. After she returned the insulin device to the cart, she removed the other glove and then performed hand hygiene. Interviewed LN1 at 03:44 PM about her hand hygiene technique. She stated, I keep one hand gloved and used the other hand to open the cart. When asked what basic principle health care workers should do after removing gloves, she stated hand hygiene. She acknowledged that after removing the single glove, her hand was contaminated until she performed hand hygiene. Observed LN1 don a pair of gloves at 3:46 PM and prepare to administer an inhaler to Resident 2. She took the inhaler and several tissues into Resident 2's room. After administering the inhaler, LN1 placed it directly on Resident 22's over-bed table, without a barrier on the table. She then assisted the resident with a drink of water. When LN1 returned to the medication cart, she again, removed a single glove and unlocked the cart. She did not perform hand hygiene after removing the glove. After replacing the inhaler in the cart, she then removed her other glove and performed hand hygiene. During a second interview at 3:52 PM, LN1 confirmed the facility had provided her education on hand hygiene and the use of sanitizers. When asked about the lack of hand hygiene after removing the first glove, she again stated she tried to have one clean hand and one dirty hand with the 1 glove on and 1 glove off technique. She again confirmed that she did not perform hand hygiene after removing the first glove and that after glove removal, hands were contaminated until hand hygiene was performed. During the same interview, LN1 explained how medical devices such as a glucometer should be disinfected. She stated that after wiping the item off, they should dwell in the disinfectant for three minutes to kill pathogens. She then added that when she disinfected the glucometer it probably was not that long. During the interview, LN1 repeatedly touched the respirator on her face, and did not perform hand hygiene. LN1 confirmed she knew hand hygiene should be performed after touching her PPE. After the surveyor asked her about touching her respirator, she performed hand hygiene. Observed Staff 3 doff PPE and exit the C wing Yellow Unit on 08/18/2020 at 4:07 PM. Staff 3 doffed gloves and then pushed on the door handle to exit the double doors to the unit. Once outside of the unit, she removed her gown and placed it in a laundry hamper. She then performed hand hygiene with an alcohol based hand rub. Staff 3 then removed the goggles she was wearing and hung them in the neck of her scrub top and walked away. She did not perform hand hygiene after removing gloves and before touching the door handle, she did not disinfect the eye protection prior to placing them is/on her uniform, or perform hand hygiene after touching the goggles. Interviewed the DON on 8/18/2020 at 04:50 PM about the observations made. The DON confirmed her expectation was that staff performed hand hygiene after glove removal, and that LN1 had missed multiple opportunities. She further stated that hand hygiene was part of basic infection control practices and could lead to the spread of pathogens such as [DIAGNOSES REDACTED]-CoV-2 ([MEDICAL CONDITION] which causes COVID-19 illness). When asked what her expectation was for the disinfection of reusable medical devices, she confirmed the facility's practice was that devices should be left to dwell in the disinfectant for 3 minutes. When asked if the manner Staff 3 implemented hand hygiene and reuse of goggles including wearing them on the uniform was a concern, she stated Yeah absolutely. With our reusable PPE we tell (staff) to disinfect it. It could spread COVID. Reviewed facility's COVID 19 Mitigation Plan on 08/18/2020. The Plan was most recently reviewed and revised by the facility on 06/26/2020. Under the procedure section for the Yellow units, it read The staff will fully doff all PPE and leave all dirty PPE in designated receptacles, perform hand hygiene. If further read under section 3.5 Infection Prevention and Control, The guidance the infection preventionist (IP) will follow will be heavily influenced from the (Local Health Department, California Department of Public Health), and the CDC. . IP will oversee the training of staff and observe for compliance of proper infection control practices including donning and doffing of PPE, hand hygiene, observance of signs and symptoms of COVID. Staff training document titled Inservice 7/31/2020 was reviewed on 08/18/2020. It read under the heading for yellow zones, You must perform proper removal of PPE and perform hand hygiene between each patient contact/visit. The form provided to surveyor on 08/18/2020 and described as the monitoring tool for hand hygiene was titled Healthcare-Associated Infectious Program Adherence Monitoring Hand Hygiene. It read Hand hygiene should be performed before and after glove use |

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<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>CDC Recommendations titled Hand Hygiene in Healthcare Settings (located on their web site https://www.cdc.gov/handhygiene/providers/index.html ) contained a section heading Introduction to Hand Hygiene. It read When and How to Perform Hand Hygiene .Immediately after glove removal CDC Recommendations titled Preparing for COVID-19 in Nursing Homes dated 6/25/2020 (located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html) read Implement a process for decontamination and reuse of PPE such as face shields and goggles. CDC Recommendations titled Strategies for Optimizing the Supply of Eye Protection (located at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html) dated 7/16/2020 read, HCP (Health care providers) should take care not to touch their eye protection. If they touch or adjust their eye protection they must immediately perform hand hygiene. The guidance further read how to reprocess reusable eye protection, While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe. Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution. Wipe the outside of face shield or goggles with clean water or alcohol to remove residue. Fully dry (air dry or use clean absorbent towels). Remove gloves and perform hand hygiene. CDC guidance titled Infection Prevention during Blood Glucose Monitoring and Insulin Administration read If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. (Located at https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html ) |
| F 0885<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | Based on record review and interview, the facility failed to inform residents, their representatives, and/or their families timely when Resident 1 tested positive for COVID-19 by 05:00 PM the following day. The facility also failed to include cumulative updates on the total number of residents and staff who had tested positive at the facility. Findings: Resident 1's electronic health records, reviewed on 08/18/2020, revealed a nursing note dated 08/08/2020 indicating positive COVID-19 test results. It further read Resident 1 was moved to the Red Zone. A copy of the test results read the Specimen Reported Date was 08/08/2020. Facility's report titled COVID testing data report LINE LIST was reviewed on 08/19/2020. It indicated facility wide resident testing had occurred on 08/05/2020, and nine residents were identified as positive on the list. Resident 1 was included in the list of positive residents. Facility communication to residents and their representatives with subject COVID INFORMATIONAL NEWSLETTER UPDATE dated 08/10/2020 with a sent time print of 08/11/2020 was provided to the surveyor upon request and reviewed on 08/17/2020. Timely communication is 5:00 PM the next day, which would have been 08/09/2020. The newsletter read in part, As of today, 08/10/20, we have 9 new confirmed residents who tested positive for COVID?19 with our most recent round of testing last week. The newsletter did not include the cumulative updates on the total number of staff and residents infected. Interviewed the Director of Nursing (DON) on 08/18/2020 at 04:00PM, she confirmed the facility was aware of Resident 1's COVID-19 test results on 08/08/2020. When asked if this information had been reported to all residents and/or their representatives by 5:00 PM on 08/09/2020, she stated I'd say no it wasn't sent. She further clarified that the newsletter was a weekly update, and they had not sent notification with each new positive result. When asked if she was aware the weekly updates should include cumulative updates of all residents and staff who tested positive she replied, I was not aware - that will be something we got to change. Facility's COVID 19 Mitigation Plan most recently reviewed and revised by the facility on 06/26/2020 was reviewed on 08/18/2020. The plan included a section titled Communication which revealed the lack of a time line for communicating to residents and their families when there was a new confirmed case in the facility. The Plan also did not address cumulative cases to be reported to residents, their representatives, or families. |