STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STOCKTON NURSING CENTER	4545 SHELLEY COURT 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, 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 quickly identified and prevented from spreading, for a census of 85, when: 1. Staff were not adequately screened for symptoms of COVID-19; 2. Residents were not monitored for symptoms of COVID-19 consistently, to allow prompt detection of infection, including oxygen saturation levels (indicates the amount of oxygen circulating in blood); 3. Hand sanitizer was not readily accessible and staff did not perform hand hygiene properly; 4. Staff did not use correct precautions (measures taken to prevent infection) for three residents (Resident 1, Resident 2, and Resident 3) with unknown COVID-19 status, and staff did not use or store personal protective equipment (PPE-includes gloves, masks, eye protection and/or gowns to cover clothing) correctly; and, 5. The facility did not have an infection preventionist to oversee the infection prevention program and provide adequate training and oversight for staff. These failures had the potential to result in spread of infection, including severe illness from COVID-19. Findings: 1. During an observation on 6/25/20, at 3:12 p.m., at the facility entrance, Certified Nurse Assistant (CNA) 3 checked the temperature of a staff member upon entry. The staff member continued into the building. No other screening questions were asked. Hand hygiene was not performed upon entry into the facility. During an interview on 6/25/20, at 3:15 p.m., CNA 3 stated, .We (those who screen) just check their (staff) temperature and if their temp is high, we ask for signs and symptoms (of COVID-19) . During an interview on 6/25/20, at 3:20 p.m., the director of nursing (DON) stated, .We just screen the temperature for staff at every entry. They (staff) are informed that if there are changes, they need to call in with symptoms. Before the outbreak (of COVID-19 in the facility) we've been checking for example if they were exposed to someone or traveled .If they have signs and symptoms, they need to call in . During an interview on 6/25/20, at 3:37 p.m., the DON stated, .It's been a while since we had the outbreak but that's when we stopped symptom screening of staff . During an interview on 6/29/20 at 12:40 p.m., Licensed Nurse (LN) 3 was asked how he was screened at the front door before his shift. LN 3 stated, .We get (temperatures) checked. No one asks about symptoms . Review of the facility record used for staff screening, Employee Roster, dated 6/29/20, indicated a column for staff names, job role, and temperature results. There was no documentation on the roster of any symptom screening for COVID-19. Review of the facility document, Screening Checklist, dated 3/16/20, indicated, ALL EMPLOYEES entering the building should be asked the following questions .Has this individual washed their hands or used alcohol-based hand rub (ABHR) on entry . The checklist directed further questioning of staff, .Ask the individual if any of the following apply to them .Fever .Sore throat .New Cough .New shortness of breath .If YES to any, ask them to not enter the building . Review of the facility policy and procedure, Employee Covid-19 Screening Instructions, dated 3/16/20, indicated, .Screener to report .immediately .any positive screen which would require further evaluation . Review of Centers for Disease Control (CDC) guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html) indicated, .Screen all HCP (healthcare personnel) at the beginning of their shift for fever and symptoms of COVID-19 . During a telephone interview on 6/29/20, at 8:45 a.m., with a member of the state healthcare associated infection team (HAI), the HAI stated, .We told them they need to have an assigned person to screen staff when entering for signs and symptoms (of COVID-19) .They (staff) were not being screened . 2. During a concurrent interview and record review on 6/29/20, at 12:30 p.m., Licensed Nurse (LN) 3 indicated residents in the North Hall had temperatures checked every shift (eight hours). There were no oxygen saturation level results. When asked when an oxygen saturation level of a resident was checked, LN 3 stated, .If they're not breathing well . LN 3 was not able to show any documentation in resident records to indicate residents were monitored for symptoms of COVID-19. During the same interview, LN 3 stated, .No one is being charted on .We do our rounds and just chart if there's something different. There's no order. We have an order to screen them every Wednesday . When asked about some of the symptoms of COVID-19, LN 3 indicated if a resident had diarrhea or a change in appetite, he would call the physician and wait for orders. LN 3 stated for muscle aches he would, .probably tell the physician and see what he orders . LN 3 was unsure if a resident with these symptoms required precautions initiated for COVID-19. During an interview on 6/29/20, at 1:20 p.m., the facility administrator (ADM) indicated residents with known or suspected COVID-19, were monitored every four hours. The residents in Center Hall were to be monitored at least every eight hours due to possible exposure to COVID-19. All other residents were to be monitored every shift. The ADM stated, .includes temperature, (oxygen saturation) and symptoms charted in the medical record . The ADM indicated all staff should be trained in this and it was included in their policy. During an interview on 6/29/20, at 1:46 p.m., the interim director of staff development (IDSD) stated, .If they are not in distress we don't check O2 sat (oxygen saturation) . During a concurrent interview and record review on 6/29/20, at 1:52 p.m., oxygen saturation levels were not routinely monitored for Resident 3, who was in the observation area in Central Hall, after discharge from the hospital. The DON stated .Resident 3 is on charting for (urinary tract infection) so they're (staff) not including O2 sat on COVID assessment . This indicated the DON and the IDSD were unaware of the facility policy for monitoring residents as stated in the mitigation plan for COVID-19. Review of the facility's Coronavirus Disease 2019 (COVID-19) Mitigation Plan for Skilled Nursing Facilities, not dated, indicated, .All residents are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks at a minimum of two times per day and documented in the clinical record . 3. During an observation on 6/25/20, at 4:12 p.m., on Central Hall, Licensed Nurse (LN) 2 administered medication to a resident in room [ROOM NUMBER] with gloves on. LN 2 exited room [ROOM NUMBER]. She did not remove the gloves and clean her hands. LN 2 poured a glass of water from the water pitcher on the medication cart for a resident standing in the hallway. With the same gloves on, LN 2 prepared medications at the medication cart in the hallway. LN 2 entered room [ROOM NUMBER] with these medications and a glucometer (medical device used to test blood sugar levels), with the same gloves on. During an observation on 6/25/20, at 4:19 p.m., on Central Hall, LN 2 exited room [ROOM NUMBER] with gloves on and set the glucometer on the medication cart in the hallway. LN 2 then removed her gloves in the hallway, did not perform hand hygiene, and put on two pairs of gloves. LN 2 removed the used test strip that contained blood from the glucometer and disposed of it in the sharp's container. LN 2 then removed one pair of gloves and applied ABHR to the set of gloves that were still on. LN 2 opened the medication cart, handled a medication container which she then replaced, and removed an insulin pen. LN 2 prepared the insulin (an injected medication used to treat high blood sugar) pen for injection and entered room [ROOM NUMBER]. During an interview on 6/25/20, at 4:44 p.m., with LN 2, LN 2 stated hand hygiene should be performed before and after contact with a resident and when gloves were removed. LN 2 stated she double gloved when using the glucometer but should not have used hand sanitizer on the gloves. LN 2 confirmed both pairs of gloves should be removed and then hand sanitizer should be used on her hands. During an observation on 6/29/20, at 12:15 p.m., there were five hand sanitizer dispensers in North Hall placed on the walls between resident rooms. Four of the dispensers were empty. There were 12 dispensers in the resident rooms. Seven dispensers were empty. During an observation on 6/29/20, at 12:44 p.m., in North Hall, Certified Nurses Assistant (CNA) 5 entered room [ROOM NUMBER]. She moved a wheelchair inside the room. CNA 5 left the room. She did not clean her hands before going in to

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) handle resident equipment, or upon exiting the room. CNA 5 went to the hall where she transported a resident via wheelchair into room [ROOM NUMBER] and placed her near the bed. CNA 5 placed the overbed table near her and then adjusted the resident's mask which was on her face. CNA 5 went back to the hallway and brought a resident via a wheelchair into room [ROOM NUMBER]. She adjusted the table and exited the room. CNA 5 left the room, went into the nurses' station and washed her hands. During an interview on 6/29/20, at 12:53 p.m., CNA 5 stated, .I'm sorry about that .We're supposed to clean our hands before and after touching anything . During a concurrent observation and interview on 6/29/20, at 12:58 p.m. with the housekeeping supervisor (HKS), the HKS stated supplies were short for the wall hand sanitizer dispensers. She indicated in order to supply enough sanitizer, they placed portable dispensers in each bathroom. The HKS went into room [ROOM NUMBER] and room [ROOM NUMBER]. There were no portable dispensers in the bathrooms. During a concurrent observation and interview on 6/29/20, at 1:06 p.m., CNA 5 checked three bathrooms in rooms and confirmed there was no sanitizer in the wall dispensers and no portable dispensers in the bathrooms. During an interview on 6/29/20, at 1:35 p.m., with the DON, the DON stated that hand hygiene should be completed before and after glove use, as well as between patient care. Review of the facility policy, Handwashing/Hand Hygiene dated Quarter 3 2018, indicated, .This facility considers hand hygiene the primary means to prevent the spread of infection .for the following situations .Before and after direct contact with residents .Before preparing or handling medications .After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident .After removing gloves .Before and after entering isolation precaution settings . 4. During an interview on 6/12/20, at 12:50 p.m., the director of nursing (DON) indicated staff were expected to use a separate gown over their clothing, during the care of each resident under investigation for COVID-19 (PUI, patient under investigation for exposure). The DON indicated residents discharged from a hospital within the past 14 days were observed for symptoms of COVID-19 in Central Station and all precautions (use of PPE) should be used. The Center Station currently had 13 residents, three who were PUI (Resident 1, Resident 2, and Resident 3). During an interview on 6/25/20, at 3:37 p.m., the DON indicated there were two residents in Central Station who had been in the facility less than 14 days. He stated, .They (staff) are using full PPE for those two (Resident 1 and Resident 3) . The DON indicated another resident (Resident 2) was on precautions due to an exposure to COVID-19. Resident 2 was in room [ROOM NUMBER]. Review of the clinical record indicated Resident 1 was discharged from a general acute care hospital (GACH) on 6/14/20. Resident 1's COVID-19 status was considered unknown due to possible exposure at the GACH and required care using precautions for 14 days, since the incubation period (the time [MEDICAL CONDITION] takes to infect someone after exposure) for COVID-19 can be up to 14 days. Resident 1 was in room [ROOM NUMBER]. Review of the clinical record indicated Resident 3 was discharged from a GACH on 6/25/20. Resident 3 was in room [ROOM NUMBER]. During a concurrent observation and interview on 6/25/20, at 4:15 p.m., Certified Nurses Assistant (CNA) 4 was wearing a light blue gown, taped to her wrists at the cuff. She also wore 2 masks, goggles, and a face shield. CNA 4 stated, .If we have enough gowns, I change it for isolation residents. There is no gown in the drawers (indicated drawers placed outside the isolation rooms) except one that is too hot . CNA 4 demonstrated how she cleaned her face shield by spraying the outside of the face shield with bleach and stated, .I put it on paper at the counter and leave it there (indicated the desk next to the computer where staff sit) . CNA 4 explained she also stored her mask on the counter, on a piece of paper and stated, .No one has taught us how to store them . Some people take them (PPE) home, or in their car, or leave it here. I wash my gown at home . During an observation on 6/25/20, at 4:25 p.m., in Central Hall, there were two signs outside the doorway of room [ROOM NUMBER] and room [ROOM NUMBER]. One sign indicated, Contact Precautions (used for infections, diseases, or germs that are spread by touching the patient or items in the room) The other indicated, Droplet Precautions (used for infection with germs that can be spread to others by speaking, sneezing, or coughing). The signs indicated HCP (health care provider) should put on a gown and gloves for contact precautions and a facemask and eye protection (face shield or goggles) for droplet precautions to enter a patient room. If the gown worn to care for a resident with unknown COVID-19 status was also worn to care for another resident, the infection can be spread. There was no signage at room [ROOM NUMBER] or room [ROOM NUMBER] to warn of precautions needed. During the same observation, Licensed Nurse (LN) 2 put on gloves. She already had a facemask and face shield on and entered room [ROOM NUMBER] to administer medications. LN 2 exited room [ROOM NUMBER] with gloves, facemask, and face shield on. LN 2 removed only the gloves and washed her hands with ABHR. LN 2 then put on gloves, still had the same facemask and eye shield on, and entered room [ROOM NUMBER] to administer medications. LN 2 did not put on a gown for room [ROOM NUMBER] as indicated by the Contact Precaution sign posted at the entrance Resident 1's room. During an interview on 6/25/20, at 4:35 p.m., LN 2 indicated two residents were on isolation due to exposure to COVID-19 by their former roommates. LN 2 stated, .I change my gloves, but I don't put a gown on. It's too hot . LN 2 indicated if residents did not have COVID-19 symptoms, there was no need to change gowns between residents to maintain precautions. LN 2 further indicated there were no residents discharged from the hospital less than 14 days ago on the central unit. LN 2 was not able to explain the purpose for using precautions for residents who had an unknown COVID-19 status for example, after hospitalization when exposure may have occurred or after a known exposure. During a concurrent interview and record review on 6/25/20, at 4:45 p.m., LN 2 reviewed the hospital discharge date for Resident 1 and indicated Resident 1 came to the facility on [DATE], 10 days prior. LN 2 checked the list of residents on isolation precautions and stated, .It says (Resident 1) until 6/29/20, so I guess so. It's not as strict here as in the COVID area . During an observation on 6/29/20, at 11:30 a.m., there were no isolation precautions signs at any of the doorways on Center Hall. LN 2 wore a blue plastic gown over her clothing. During an observation on 6/29/20, at 11:40 a.m., the interim director of staff development (IDSD) posted signage for contact and droplet precautions at the doorway of room [ROOM NUMBER]. Resident 3 was in room [ROOM NUMBER] and was discharged from a GACH four days prior. LN 2 was observed going into room [ROOM NUMBER] without changing her gown or placing another disposable gown over it. LN 2 exited room [ROOM NUMBER] and subsequently entered room [ROOM NUMBER] wearing the same gown. During an interview on 6/29/20, at 11:50 a.m., LN 2 was asked to describe how she was trained to care for residents with unknown COVID-19 status due to possible or known exposure and prevent it from spreading. LN 2 stated, We don't use PPE because they're (residents) not positive .I change gloves every patient and wash hands. No more gown changes .They're not sneezing. If they aren't, the same gown is OK. Gloves are the main method of preventing spread. No one has symptoms here . During a concurrent observation and interview with LN 2 at 12:05 p.m., LN 2 wiped the front of her gown and then the sleeves with a disinfectant wipe and stated, .Sometimes I disinfect the gown with a wipe . During an interview on 6/29/20, at 1:20 p.m., the Administrator (ADM) stated, .Center (the station where exposed residents and admissions from the hospital were observed) is our biggest concern . During an interview on 6/29/20, at 1:35 p.m., with the DON, the DON indicated HCP should put on a gown, gloves, facemask, and face shield for care of residents on contact and droplet precautions. During an interview on 6/29/20, at 5:06 p.m., the DON indicated training on use of the reusable, washable gowns was not completed, and he was not aware staff were using them, although some product had been distributed to staff. The DON further indicated the face shields should not be cleaned. They should be discarded. The DON was not aware staff were cleaning their PPE at the nurses' station and indicated this was not acceptable. Review of the facility policy, Respiratory Virus (COVID-19 .) Prevention and Control dated quarter 1 2020, indicated, .The same gown will not be worn for care of more than one resident . Review of Centers for Disease Control (CDC) guidelines at the following address: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html, Preparing for COVID-19 in Nursing Homes dated 5/28/20, indicated, .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 respirator .eye protection .gloves and gown when caring for these residents . 5. During an interview on 6/12/20, at 12:45 p.m., with the Administrator (ADM), the ADM indicated the director of staff development (DSD) was no longer employed and the infection preventionist (IP) duties were being performed by the director of nursing (DON) and the assistant director of nursing (ADON). The ADM indicated neither had completed an IP training class. During an interview on 6/25/20, at 3:20 p.m., the DON indicated the facility did not have an IP yet. He confirmed he was still performing the tasks related to infection prevention. The DON indicated he was aware the IP role required a full-time staff with the necessary training. During an interview on 6/25/20, at 3:37 p.m., the DON indicated he monitored staff for compliance with PPE use and handwashing while making his rounds in the mornings. He did not document any audits of staff compliance and had no record of gaps in staff practices. During an interview on 6/29/20, at 2:20 p.m., the DON indicated the facility did not yet have a trained IP. Review of training provided to staff indicated an in-service was conducted on 2/18/20. The subjects covered were, COVID-19/Influenza (flu) outbreak, PPE, Handwashing . Another training was provided to staff on 5/26/20. There were no further records of in-services conducted. Review of the letter sent to the facilities, AFL 20-52, dated 5/11/20, indicated, .The SNF (skilled nursing facility) must have a full-time, dedicated Infection Preventionist . Review of CDC guidelines (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html)

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) indicated, .Facilities should assign at least one individual with training in IPC (infection prevention and control) to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices.