STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A340	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTWOOD MANOR - 104	**1130 MONACO 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, and record review, the facility failed to provide infection prevention and control measures to prevent the possible spread of COVID-19 when: 1. Isolation precautions (used to help stop the spread of germs from one person to another) were not followed; 2. Resident (RES) 3, RES 4, RES 8 and RES 9 whom were positive for COVID-19 ([MEDICAL CONDITION] that causes illness, confirmed by a lab test) were placed in rooms with RES 1, RES 2, RES 5, and RES 7 whom were not yet confirmed to have COVID-19, but had symptoms. Positive COVID-19 patients were cohorted (the placement of similar people in the same location) in the same area as patients not yet confirmed to have COVID-19, but had symptoms (people with symptoms of [MEDICAL CONDITION], but not confirmed by a lab test to have [MEDICAL CONDITION]); and 3. Staff had not completed hand hygiene (act of cleaning one's hands to remove harmful and unwanted substances) between tasks for RES 10 and RES 11 This failure put residents at risk of contracting COVID-19, with the potential of causing illness or death. Findings: 1. During an observation, on 7/15/20, at 1:20 p.m., on Station 2, Certified Nurse Assistant (CNA) 3 entered room [ROOM NUMBER] with a gown, gloves, facemask and eye shield on and carried the resident's urinal into the bathroom of room [ROOM NUMBER]. CNA 3 exited room [ROOM NUMBER] and removed only the gloves. CNA 3 then put on a new pair of gloves and entered room [ROOM NUMBER]. CNA 3 exited room [ROOM NUMBER] with a resident's meal tray and removed only the gloves. CNA 1 then put on a new pair of gloves and entered room [ROOM NUMBER]. CNA 3 exited room [ROOM NUMBER] and removed only the gloves. CNA 3 then entered room [ROOM NUMBER] and assisted the resident in bed. CNA 3 only removed and put on a new pair of gloves between each resident's room but did not put on a new gown. rooms [ROOM NUMBERS] had signage at the door that indicated the residents were on contact precautions (to prevent spread by contact either with the resident or items in the resident's environment) and droplet precautions (prevent spread by droplets which may be transmitted during coughing, talking or sneezing). The contact precaution sign indicated for staff to put on a gown and gloves before entry into the room and to remove the gown before exiting the room. During an interview, on 7/15/20, at 1:28 p.m., with CNA 3, when asked why the gown was not changed between resident rooms, CNA 3 stated, gowns are only changed when they are soiled, but it's different here so we don't need to change it between residents, according to the Director of Staff Development (DSD), but otherwise we would anywhere else in the facility. During a concurrent interview, on 7/15/20, at 2:21 p.m., with the administrator (ADM), the Director of Nursing (DON), and the Assistant Director of Nursing (ADON)/Director of Staff Development (DSD)/Infection Preventionist (IP), when asked about why their staff did not change gowns between rooms, they stated as long as it wasn't dirty or soiled, in order to conserve on gown usage, they did not want the staff to change gowns. They denied any issues getting personal protective equipment (PPE) (special clothing and/or equipment worn by staff to protect against germs that cause infection) delivered, stating anytime they need something, corporate delivers it to their door and leaves it out front for them. When asked the expectation for what PPE the staff should use with residents whom had symptoms of COVID-19 or had tested positive, it was explained staff should use a gown, goggles, facemask, or a N-95 (respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles). Review of an All Facilities Letter (AFL) Summary published by California Department of Public Health, dated 04/13/20, with a subject line, Coronavirus Disease 2019 (COVID-19) Optimizing the Use of Personal Protective Equipment (PPE), indicated, HCPs (healthcare personnel) should remove only gloves and gowns and perform hand hygiene between residents with the same diagnosis (confirmed COVID-19) while continuing to wear the same respirator or facemask and eye protection (face shield or goggles). Review of the Centers for Disease Control and Prevention (CDC), dated 5/25/20, Preparing for COVID-19 in Nursing Homes indicated, If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different patients unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections, (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html). 2. During an observation, on 7/15/20, at 1:18 p.m., on Station 2, Rooms 1, 2, 3, 4, 5, 6, 7, 8, and 9 were in an area closed off by plastic sheeting draped between the nurse's station and after the doorway of room [ROOM NUMBER]. The other end of the hall was closed off by a set of double doors. Staff were observed to be working with all the residents in this area. During an interview, on 7/15/20, at 1:50 p.m., on Station 2, with Certified Nurse Assistant (CNA) 1, CNA 1 stated, she did not know which residents or rooms (Rooms 1, 2, 3, 4, 5, 6, 7, 8, and 9) the positive residents were in and what residents had only symptoms, but not yet confirmed negative or positive for COVID-19. During a concurrent interview on 7/15/20, at 2:21 p.m., with the Administrator (ADM), the Director of Nursing (DON), and the Assistant Director of Nursing/Director of Staff Development/Infection Preventionist (ADON/DSD/IP), they stated it was appropriate to put the symptomatic residents who had pending COVID-19 tests and were not confirmed positive with the confirmed COVID-19 positive because the test results showed most of the symptomatic were positive when their results came in. Therefore, they assume all the symptomatic residents are COVID positive prior to getting their test results and decided to keep all the COVID positive and the unconfirmed residents with pending test in the same area. They further stated that they tried to keep the COVID positive residents and the presumed positive residents in different rooms, but it wasn't always possible to separate them because they didn't have enough rooms. Review of a facility document, (not titled), dated 7/15/20, indicated, RES 1, RES 2, RES 5, and RES 7 were resident suspect (residents suspected to have COVID-19, but not yet confirmed). The document indicated, RES 3, RES 4, RES 8, and RES 9 were resident positive (residents confirmed to have COVID-19). RES 1 and RES 2, both resident suspect and RES 3, resident positive were in room [ROOM NUMBER]. RES 5 and RES 6, both resident suspect and RES 4, resident positive, were in room [ROOM NUMBER]. RES 7 resident suspect and RES 8 and RES 9, both resident positive were in room [ROOM NUMBER]. Review of facility documents, Resident Listing Report, and (not titled), both dated 7/15/20, indicated, residents that were positive for COVID-19 and residents suspected for COVID-19 resided in Rooms 1, 2, 3, 4, 5, 6, 7, 8, and 9. Review of the facility document, titled, Coronavirus Disease 2019 (COVID-19) Mitigation Plan for Skilled Nursing Facilities, (not dated), indicated, Residents with active COVID-19 infection confirmed by testing .have been separated from residents who are not infected or have unknown infection status, and All residents with COVID-19 infection confirmed by testing, or those residents who are recovering from COVID-19 infection, have been separated from residents who are not infected or have unknown infection status are placed in dedicated COVID-19 positive wings. Review of the facility document, titled, (facility name) COVID 19 MITIGATION PLAN, (not dated), indicated the facility will have a Designation of space that can safely be used to isolate COVID+ residents without posing a risk to the life and safety of other residents or staff, and the section, COHORTING RESIDENTS DURING COVID-19, indicated, The facility will monitor guidance from CDC and adjust procedures for cohorting accordingly . The facility document, indicated, If residents test positive, the facility will keep positive residents in a designated space . Review of the Centers for Disease Control and Prevention (CDC), dated 7/15/20, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic Infection Control Guidance indicated, It might not be possible to distinguish patients who have COVID-19 from patients with other respiratory viruses. As such, patients with different respiratory pathogens might be cohorted on the same unit. However, only patients

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A340	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CRESTWOOD MANOR - 104	**1130 MONACO 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	(continued... from page 1) with the same respiratory pathogen may be housed in the same room. For example, a resident with COVID-19 should ideally not be housed in the same room as a patient with an undiagnosed respiratory infection or a respiratory infection caused by a different pathogen (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html). Review of the CDC, dated 4/30/20, Responding to Coronavirus (COVID-19) in Nursing Homes 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) Review of the CDC, dated 5/25/20, Preparing for COVID-19 in Nursing Homes indicated, Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of [DIAGNOSES REDACTED]-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html) 3. During an observation on 7/15/20, at 9:36 a.m., Certified Nurse Assistant (CNA) 2 was assisting RES 10 in the activity room. CNA 2 adjusted RES 10's face mask, removed his head gear, and handed him an activity tool to work on. After assisting RES 10, CNA 2 then left the activity room and stopped at the hallway just outside the activity room to talk to RES 11. CNA 2, without performing hand hygiene, touched RES 11's wheelchair and started wheeling RES 11 down the hallway. During a subsequent interview with CNA 2, when asked what should he have done before and after resident care, he stated, he should have washed his hands after caring for RES 10 and before touching RES 11 wheelchair. He also added, he did not wash his hands because he did not have access to the handwashing sink in the activity room and hand sanitizer was at the nurses' desk down the hallway. During an interview with the ADON/DSD/IP on 7/15/20, at 11:05 a.m., she stated, she would have expected the staff to perform hand washing or hand hygiene before and after resident care. Review of the facility's policy titled, Hand Hygiene effective date 5/18/20, indicated, .that all staff will reduce or prevent the transmission of pathogens (microorganisms that can cause diseases) by performing hand hygiene before and after providing care to each person served . According to Centers for Disease Control and Prevention (CDC) website, Hand Hygiene Guidance, reviewed 1/30/2020, indicated, .Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: immediately before touching a patient .after touching a patient or the patient's immediate environment . https://www.cdc.gov/handhygiene/providers/guideline.html