STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056198	A. BUILDING _____ B. WING _____	07/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KIT CARSON NURSING & REHABILITATION CENTER	811 COURT STREET JACKSON, CA 95642

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 -** Few	**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 control measures were followed to prevent the occurrence, and the spread, of COVID-19 when: 1. Staff did not handle personal protective equipment (PPE, a process used to prevent the spread of infection by creating a barrier) in a safe and sanitary manner; 2. Staff did not wear the appropriate PPE when entering the facility's Yellow zone; 3. Symptom surveillance (a system designed to identify possible communicable diseases or infections before they can spread to other persons in the facility) for COVID-19 among residents was incomplete; and 4. Family/representative notification regarding COVID-19 updates were not completed per facility policy. These failures had the potential to put residents and staff at risk of exposure to, and cause the spread of COVID-19 infection, and left residents families/representatives uninformed of the facilities COVID-19 status. Findings: 1. During an observation on Station 2 (a wing of the facility where residents reside) on 7/17/20, at 10:20 a.m., Licensed Nurse (LN) 1 placed her N95 (a mask used to filter air) on the counter at the nurse's station. During a subsequent observation of LN 1 on 7/17/20, at 10:43 a.m., LN 1 was observed walking down the hallway near station 2's nurses station holding her N95 by the cloth part in her bare hand, and the mask was folded in half with the outside of the mask exposed. During a concurrent observation and interview with LN 1 on 7/17/20, at 11:50 a.m., LN 1 was observed with her N95 mask around her neck. LN 1 confirmed she should not have set her mask on the nurse's station counter, carried it with bare hands, or have worn it around her neck. During an interview with the director of staff/infection preventionist (DSD/IP) on 8/10/20, at 11:36 a.m., the DSD/IP stated PPE should be worn in a safe and sanitary manner, and should not be set down on high touch surfaces. During an observation on 7/17/20, on Hall 5, (an area of the facility where residents reside) at 10:33 a.m., two disposable surgical gowns (a disposable gown worn by staff members to prevent the spread of infection from one resident to the other) were observed hanging over the top of room [ROOM NUMBER]'s door touching each other. During an interview with certified nurse assistant (CNA) 1 on 7/17/20, on Hall 5, at 10:45 a.m., CNA 1 stated the surgical gowns had been on the top of the door since she arrived at approximately 7 a.m. CNA 1 confirmed the surgical gowns should have been disposed of, not hung on the door of the resident's room. During an interview with the DSD/IP on 8/10/20, at 11:36 a.m., the DSD/IP stated surgical gowns should not be hung on the top of a resident's door when not in use, and should have been disposed of at the end of the shift. 2. During a concurrent observation and interview with Certified Nurse Assistant (CNA) 1 on 7/17/20, on Hall 5 (an area of the facility where residents reside), at 10:45 a.m., CNA 1 was observed walking out of room [ROOM NUMBER] without eye protection on. On the wall outside of room [ROOM NUMBER] was a sign which indicated the room was on droplet based precautions with a picture depicting required eye protection. CNA 1 confirmed she did not have on eye protection in room [ROOM NUMBER], but should have. During an interview with the admissions coordinator/marketing director (AC/MD) on 7/17/20, at 12:45 p.m., the AC/MD confirmed room [ROOM NUMBER] was in the facility's Yellow zone. The AC/MD went on to say the facility has not admitted new residents and the residents in the Yellow zone had signs or symptoms of COVID-19, or had been exposed to COVID-19. The AC/MD confirmed staff entering rooms in the Yellow zone should be wearing an N95 mask, faceshield or goggles, surgical gown, and gloves. During an interview with the DSD/IP on 8/10/20, at 11:36 a.m., the DSD/IP stated eye protection should always be worn in the Yellow zone. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed Coronavirus (COVID-19), not dated, the P&P indicated, .It is the policy of this facility to minimize exposures to respiratory pathogens .including the use of eye protection . 3. During an observation on Station 1 (a wing of the facility where residents reside) on 7/17/20, at 11:16 a.m., a binder on Station 1's nurse's counter contained facility documents titled, COVID WORKSHEET. The worksheets listed resident names, room numbers, and had areas to document the temperature and oxygen saturation (the amount of oxygen saturation in red blood cells) of each resident three times per day. The worksheets further revealed temperature and oxygen saturations were not documented consistently for the residents. During a record review of the COVID WORKSHEET, dated 7/15/20, the worksheet revealed temperature and oxygen saturation were not documented for residents in Rooms 1A through 8B for the morning, or the night shift. During a record review of the COVID WORKSHEET, no date, the worksheet revealed temperature and oxygen saturation were not documented for residents in Rooms 9A through 22D for the morning, or the night shift. During a record review of the COVID WORKSHEET, dated 7/16/20, the worksheet revealed temperature and oxygen saturation were not documented for residents in Rooms 1A through 22D for the morning shift. During an observation on 7/17/20, at 11:26 a.m., a binder was observed on Station 2's (an area in the facility where residents reside) nurse's counter which contained facility documents titled, COVID WORKSHEET. The worksheets revealed temperature and oxygen saturations were not documented consistently for residents. A record review of the COVID WORKSHEET, dated 7/15/20, revealed temperature and oxygen saturation were not documented for residents in rooms 32A through 42C for the morning shift. A record review of the COVID WORKSHEET, dated 7/16/20, revealed temperature and oxygen saturation were not documented for residents in rooms 32A through 40B for the morning, or the evening shift. A record review of the COVID WORKSHEET, no date, for residents in Rooms 41A through 42C revealed temperature and oxygen saturation were not documented for the morning, or the evening shift. During an interview with licensed nurse (LN) 2 on 7/17/20, at 11:30 a.m., LN 2 stated temperature and oxygen saturation should be taken every shift, for every resident, to monitor for signs and symptoms of COVID-19, and be documented on the worksheet. LN 2 confirmed the worksheets had missing temperatures, and oxygen saturations. During an interview with the DSD/IP on 8/10/20, at 11:36 a.m., the DSD/IP confirmed temperature and oxygen saturation for every resident, three times per day, should be documented on the COVID WORKSHEET. The DSD/IP stated the process was used to screen residents for COVID-19, and the worksheets should not have missing documentation. During a review of the facility's P&P titled, Infection Control Policies/Practices/Programs, revised 06/2012, the P&P indicated, .2. The objectives of our infection control policies, practices and programs are to .d. Maintain records of infection surveillance . 4. During an interview with the admission coordinator/marketing director (AC/MD) on 7/17/20, at 12:45 p.m., the AC/MD stated she was responsible for communicating COVID-19 updates to resident families/representatives. The AC/MD went on to say she called all resident families/representatives and updated them about the most recent positive COVID-19 case in the facility. Continuing the above interview with the AC/MD and a record review on 7/17/20, a list of Resident Contacts, dated 7/3/20, were discussed. The list displayed resident names with their family/representative contact information. At the top of the list in handwritten print, the list read, Mark all called and notified. Further review of the list revealed check marks in handwritten print next to some of the resident contacts. The AC/MD verified the list of contacts was how she kept track of family/representative notification when she called them. When asked why some resident contacts did not have a check mark, the AC/MD stated she must have missed them. The Resident Contacts list revealed 36 families/representatives did not have check marks by their names. During a review of the facility's P&P titled, Resident, Representative & Family Notification for Covid-19 Positive, revised 5/20/20, the P&P indicated, .It is the policy of (facility name) to notify Residents, Representatives, and Family members .of any confirmed cases of COVID-19 and/or a new set of three or more residents and staff with new onset respiratory symptoms .

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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