STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055289	A. BUILDING _____ B. WING _____	09/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LODI CREEK POST ACUTE	321 WEST TURNER ROAD LODI, CA 95240

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, and record review, the facility failed to provide infection control measures to avoid cross contamination and spread of COVID 19 from positive residents over to negative residents when licensed nursing staff left a COVID-19 resident room and prepared to enter a non-Covid-19 resident room and staff did not close a zip-up barrier at the entrance to the room (this plastic barrier served to isolate the room from any other room). This failure had the potential to result in COVID 19 to be transmitted and spread further in the facility by staff from the known COVID 19 positive residents to the known COVID 19 negative residents in the facility. This jeopardized the health and safety of all residents and staff within the facility, for a facility resident census of 59. Findings: The Department received an anonymous complaint, dated 8/21/20, regarding an allegation that the facility's employees were providing care to COVID 19 positive residents and subsequently to COVID 19 negative residents. Upon entrance to the facility on [DATE] at 2:31 p.m., the facility was noted to have a census of 59. The facility had a total of 19 active COVID 19 positive residents, 4 residents who were Persons Under Investigation (PUIs), and 36 COVID 19 negative residents. The COVID 19 positive residents were identified as red zone, the PUIs as yellow zone, and the COVID 19 negative residents as green zone. During a concurrent observation and interview with the Director of Nursing (DON) on 9/4/20 at 2:50 p.m., each resident room in one hallway had a zip up plastic barrier at the entrance of the room, replacing the main door. The plastic barriers were each labeled with either a red, yellow, or green zone sign posted on the door, indicating the COVID 19 status of the residents inside the rooms. The DON stated the CNAs (certified nursing assistants) assigned to the red zone rooms only cared for residents in the red zones. The DON further stated the licensed nurses are assigned to all zones since they are not with the patients for a long period of time and they wear personal protective equipment (PPE). During an interview with the Licensed Nurse (LN) on 9/4/20 at 2:59 p.m., the LN stated she was assigned to Station 1 and was caring for red, yellow, and green zone residents. During an observation on 9/4/20 at 4:30 p.m., the LN was observed putting on PPE prior to entering a resident's room marked as a red zone. The LN left the room and prepared to go to another resident's room marked as a green zone. The LN stated she puts on a gown whenever she entered a different room. The LN confirmed she intended to enter the resident room marked as a green zone. During an observation of the facility residents' rooms on 9/4/20, at 4:45 p.m., the residents' rooms were marked green, yellow, and red. The residents' rooms marked as green were 5, 9, 14, 15, 17, 19, 20, 22, 25, and 27. The residents' rooms marked as yellow were 1, 2, 3, 4, 6, 10, 11, and 16. The residents' rooms marked as red were 8, 12, 13, 18, 21, 23, 24, 26, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, and 40. Also observed, was a staff member providing care in a resident's room and the zip-up plastic partition was open approximately one foot from the bottom. A review of the facility's floor plan on 9/4/20, revealed the following: room [ROOM NUMBER] (green) was next to room [ROOM NUMBER] (yellow), room [ROOM NUMBER] (green) was next to room [ROOM NUMBER] (red), room [ROOM NUMBER] (red) was in between room [ROOM NUMBER] (yellow) and room [ROOM NUMBER] (green), room [ROOM NUMBER] (red) was in between room [ROOM NUMBER] (yellow) and room [ROOM NUMBER] (green), room [ROOM NUMBER] (red) was in between room [ROOM NUMBER] (yellow) and room [ROOM NUMBER] (green), room [ROOM NUMBER] (green) was next to room [ROOM NUMBER] (red), room [ROOM NUMBER] (red) was next to room [ROOM NUMBER] (green), and room [ROOM NUMBER] (green) was next to room [ROOM NUMBER] (red). There was no distinct area for rooms identified as a red zone to be cohorted together and there was no separation of assigned units for staff. During an interview with the LN on 9/4/20, at 5:40 p.m., the LN stated she was assigned to Rooms 3, 5, 7, 8, 9, 11, 13, 15, 17, 19, 21, 23, 25, 27, 30, 34, and 35. She further stated, when passing her medications, she started from room [ROOM NUMBER] and worked herself down the hallway. She confirmed she entered residents' rooms marked green, yellow, and red. During an interview with the Administrator (ADM) on 9/4/20 at 6:39 p.m., the ADM stated they were unable to cohort all COVID positive residents in one area because the residents became positive at different times, indicating they would finish quarantine on different days. The ADM further stated their local County Department and the Department of Public Health provided guidance to not move the COVID positive residents and leave them in their rooms. A review of the facility's staffing assignments dated 9/4/20 indicated there were 3 LNs assigned to work every shift. The document further indicated the LNs were assigned to Station 1, Station 2 and Station 3. A review was conducted on 9/9/20 of the CDC guidelines titled, Preparing for COVID 19 in Nursing Homes, dated 6/25/20, at https://www.cdc.gov/coronavirus/2019 ncov/hcp/long term care.html, indicated, Identify space in the facility that could be dedicated to care for residents with confirmed COVID 19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID 19 . Identify HCP who will be assigned to work only on the COVID 19 care unit when it is in use . A review was conducted on 9/9/20 of the CDC guidelines titled, Responding to Coronavirus (COVID 19) in Nursing Homes, dated 4/30/20, at https://www.cdc.gov/coronavirus/2019 ncov/hcp/nursing homes responding.html, indicated, . Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID 19 . Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID 19 care unit could be a separate floor, wing, or cluster of rooms . Assign dedicated HCP to work only on the COVID 19 care unit. At a minimum, this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID 19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility.

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.