STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555170	A. BUILDING _____ B. WING _____	09/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINDSOR POST-ACUTE CENTER OF ARVIN	**323 CAMPUS DRIVE ARVIN, CA 93203**

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** - Many	**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 implement infection control practices as evidenced by: 1. There were 19 of 70 residents (Resident 1, Resident 2, Resident 3, Resident 4, Resident 5, Resident 6, Resident 7, Resident 8, Resident 9, Resident 10, Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, Resident 18, and Resident 19) who were not appropriately placed in designated spaces assigned for Persons-Under-Investigation (PUI-exhibiting the coronavirus symptoms, has a history of exposure to COVID-19, or admitted residents from the hospital), confirmed COVID -19 (serious respiratory infection caused by the coronavirus) positive, and non-COVID. 2. The PUI and the COVID-19 positive rooms were kept wide open. 3. Staff education on Infection Prevention and Control was not provided from 1/20 to 6/20. 4. The plastic barrier separating the COVID-19 Unit from the PUI area was not properly sealed. 5. The reusable N95 (a close-fitting mask, offers enhanced protection for the wearer) masks were not properly stored, and staff did not perform hand hygiene before of after touching the mask. 6. The sharps container in the COVID-19 Unit was not mounted and properly secured. 7. The PUI areas and the COVID-19 Unit were not supplied with hand sanitizers and trash receptacles after used and contaminated gowns and masks were removed. 8. The Infection Control Preventionist (ICP) was not knowledgeable on the proper surveillance and reporting, and integration of Infection Prevention with the Quality Control Plan. 9. Transmission-based precaution signage were not posted upon entrance to the COVID-19 Unit. 10. The Certified Nursing Assistant (CNA) working in the COVID-19 unit did not correctly perform doffing (take off) of Personal Protective Equipment (PPE- is protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection). These failures had the potential to place residents and staff at risk for harm, and could result in cross-contamination and spread of infectious diseases. Findings: 1. During a concurrent observation and interview, on 8/13/20, at 10 AM, with the Director of Nursing (DON), the Administrator, and the Infection Control Preventionist (ICP), A-Wing hallway, Resident 1 was identified as a PUI. Resident 1's room was wide open. Resident 1 was placed in the hallway with eight residents who tested negative, and did not show signs and symptoms of COVID-19 infection. DON stated it was not easy to move patients around. During a concurrent observation and interview, on 8/13/20, at 10:10 AM, with the DON, the Administrator, and the ICP, in the B-Wing hallway, five PUI residents (Resident 2, Resident 3, Resident 4, Resident 5, and Resident 6) were placed in the hallway with 17 residents who were COVID-free. The Administrator stated it was better to keep the residents in their own rooms rather than move them. During a concurrent observation and interview, on 8/13/20, at 11 AM, with the DON, in the C-Wing hallway, designated as the COVID-19 Unit or red zone, Resident 19, who was COVID negative, was placed among the nine laboratory confirmed COVID-19 positive residents: Resident 11, Resident 12, Resident 13, Resident 14, Resident 15, Resident 16, Resident 17, and Resident 18. DON stated, (Resident 19) goes to [MEDICAL TREATMENT] three times a week. (Resident 19) is not COVID positive. All her tests were negative. She has been in this room since 8/4/20 when we opened this area for our COVID positive residents. During a concurrent observation and interview, on 8/13/20, at 11:05 AM, with the Licensed Vocational Nurse (LVN) 1, in the COVID-19 Unit, Resident 19 was not in her room. LVN 1 stated, (Resident 19) was sent to the hospital at 4 AM today because she developed shortness of breath and cough. room [ROOM NUMBER] was her room and she had been there since 8/4/20 when they made this hallway the COVID-19 Unit. During a review of the facility's policy and procedure (P&P) titled, Designation of Spaces, undated, the P&P indicated, It is the policy of this facility to protect our residents, staff, and others who may be in our facility from harm. To accomplish this, we have developed procedures and treatment of [REDACTED].Yellow- Facility will place all unknown asymptomatic residents in Yellow space.Green-Facility will place all confirmed negative residents and recovered residents in the Green space. 2. During a concurrent observation and interview, on 8/13/20, at 10 AM, in the A-Wing hallway, with the DON, Administrator, and IP, the door in room [ROOM NUMBER], a PUI room, was wide open. DON verified the findings. During a concurrent observation and interview, on 8/13/20, at 10:10 AM,with the DON, Administrator, and ICP, in the B-Wing hallway, the doors in rooms [ROOM NUMBER], designated PUI rooms, were wide open. DON verified the findings. During a concurrent observation and interview, on 8/13/20, at 10:50 AM, with the DON, Administrator, and ICP, the doors in Rooms, 8 and 9, designated PUI rooms and adjacent to the COVID-19 Unit, were wide open. DON verified the findings. During a concurrent observation and interview, on 8/13/20, at 11 AM, with the DON, in the COVID-19 Unit, the doors in Rooms 11, 12, 14, 15, 16, 17, 18, and 19 were wide open. DON verified the findings. During a review of the Centers for Disease Control (CDC) Guidance on Coronavirus Disease 2019 (COVID-19) titled, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease (COVID-19) in HealthCare Setting, dated 5/18/20, the document indicated, 3. Patient Placement.place a patient with known or suspected COVID-19 in a single person room with the door closed. 3. During an interview on 8/13/20, at 1:30 PM, with the ICP, ICP stated, I have assumed this ICP position only in June, 2020. We have no records of Infection Prevention and Control staff education since the Director of Staff Development left in January, 2020. ICP was unable to provide documentation of staff education for a period of six months from 1/20 to 6/20. During a concurrent interview and record review, on 8/13/20, at 1:40 PM, with the ICP, The Inservice Training Record on Donning (put on) and Doffing (take-off) of Personal Protective Equipment (PPE), dated 7/16/20 was reviewed. The record indicated only 22 staff out of 80 employees, signed and attended the training. The Inservice Training Records on Facemasks for Residents Use, dated 7/17/20, indicated seven staff signatures out of 80 employees. The Inservice Training Record on Extended Use of N95 Masks and the Use of Face Shield, dated 7/24/20, indicated 21 staff signatures out of 80 employees. ICP stated she did not have a process to capture the employees who did not attend the inservice training. The cumulative total of the three staff inservices given was 50, which is 63% (percent) of the staff for education. During a review of the CDC Guidance on COVID-19 titled, Interim Infection Prevention and Control Recommendations for Patients With Suspected or Confirmed Coronavirus Disease (COVID-19) in HealthCare Settings, dated 5/18/10, the document indicated,9. Train and Educate HealthCare Personnel (HCP): Provide HCP with job or task-specific education and training on preventing transmission of infectious agents, including refresher training. Ensure HCP are educated, trained, and have practiced the appropriate use of PPE prior to caring for a patient, including attention to correct use of PPE and prevention of contamination of clothing, skin, and the environment during the process of removing such equipment. 4. During a concurrent observation and interview on 8/13/20, at 9:45 AM, with ICP and the DON, a clear plastic barrier was observed to be taped to the ceiling and walls on the C-Wing hallway, separating the COVID-19 unit (red zone) from the rest of the hallways. The plastic had a circular hole in it on the lower right quadrant approximately ten centimeters (a unit of measurement) in diameter. The plastic was not securely taped to the ceiling and walls, allowing for large gaps in the barrier. The ICP and DON validated the findings. 5. During a concurrent observation and interview on 8/13/20, at 9:27 AM, with ICP, in the conference room, three tables and a chair were observed covered with brown paper bags, labeled with a staff name. The brown bags were not arranged in an organized manner. The bags were labeled with the staff names, but staff

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 -** Many	(continued... from page 1) would have to touch others brown bags to sort and look for his/her own brown bag. The ICP stated the bags were used to store the weekly reusable N95 masks provided to the staff. Each staff would have four or five brown bags, depending on their schedule, and they would store their used N95 masks in the brown bags. When the staff returns to work he or she would use the mask in rotation according to their work schedule. The ICP validated the potential for cross-contamination as staff looked through others bags to find their own, and stated each staff should have their own bin to properly store their brown bags with their used masks. During a concurrent observation and interview on 8/13/20, at 1:50 PM, the LVN 2, entered the conference room and looked for her brown bag. Without performing hand hygiene, she pulled her reused N95 mask out of her brown bag. LVN 2 looked through other brown bags, and pulled a reused N95 mask from another brown bag and carried it with her going outside. LVN 2 stated, I am taking this mask to another licensed nurse. During a concurrent observation and interview, on 8/13/20, at 2 PM, in the conference room, with ICP, CNA 2 removed her used N95 mask and placed it inside her brown bag. CNA 2 did not perform hand hygiene. ICP validated the findings. During a review of the facility's policy and procedure (P&P) titled, Hand Hygiene, dated 1/10/19, the P&P indicated, Employees are required to wash their hands thoroughly: Before beginning work day, After touching objects that may be soiled . During a review of the facility's policy and procedure (P&P) titled, Extended Use of N95 Respirators, dated 7/23/20, the P&P indicated, HCP will perform hand hygiene when outside of masks is touched. 6. During a concurrent observation and interview on 8/13/20, at 11:02 AM, with the DON, inside the COVID-19 unit, a sharps container (a puncture resistant box that keeps needles, lancets, or other medical supplies with sharp edges contained for disposal) was observed on the hand rail next to the medication cart. The DON and LVN 1 confirmed the sharps container was not mounted on the cart. LVN 1 took the sharps container off of the railing and placed it on the floor. The DON stated that the medication cart was rented for the COVID-19 unit and that there was no place on the cart for mounting the sharps container. 7. During a concurrent observation and interview on 8/13/20, at 11:20 AM, outside the COVID-19 unit, with the DON, there was no alcohol-based hand sanitizer for the staff to perform hand hygiene after removing their PPE. The DON validated there were no supplies available for staff to perform hand hygiene outside of the COVID-19 unit. 8. During a concurrent interview and record review, on 8/13/20, at 1:20 PM, with the ICP, ICP stated for surveillance activities she monitors vital signs of the COVID positive residents, donning and doffing of PPE, and handwashing. ICP was unable to show documentation of current surveillance data. ICP stated she was unaware of how to properly conduct infection control surveillance, and had not reported any surveillance data of identified infection control issues to the Quality Control Committee. During a review of the facility's policy and procedure (P&P) titled, Infection Control Surveillance, dated 1/20/19, the P&P indicated, 3. The Infection Control Practitioner provides surveillance data and carries out or promotes many of the prevention and control measures that are adopted as a result of surveillance activities.4. Maintaining current surveillance data allows the Infection Control Practitioner to present an accurate, quantitative and timely picture of most infection problems that might arise. It also allows for monitoring the effect of intervention strategies in infection rates. 9. During a concurrent observation and interview on 8/13/20, at 11:20 AM, with the DON outside the entrance to the COVID-19 unit, the signage on the door indicated, Danger No Smoking. Oxygen in Use. Required signage instructing staff of the PPE required to enter the unit was not observed. The DON validated the lack of required signage. During a review of the Centers for Disease Control (CDC) Guideline titled, Responding to Coronavirus (COVID 19) in Nursing Homes, dated 4/30/20, the Guideline indicated, Place signage at the entrance to the COVID 19 care unit that instructs HCP (healthcare personnel) they must wear eye protection and an N95 or higher level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. 10. During a concurrent observation and interview on 8/13/20, at 10:42 AM, with the CNA 1, on the COVID-19 unit, CNA 1 demonstrated how to Don and Doff PPE. CNA 1 did not follow the guidance for proper donning and doffing PPE. CNA 1 did not perform hand hygiene before she put on her gown, or after each PPE was removed. CNA 1 acknowledged she did not perform hand hygiene when she removed her gloves, isolation gown, faceshield, and mask. During a review of the CDC Guideline titled Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID 19, dated 6/3/20, the Guideline indicated, PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step by step process should be developed and used during training and patient care. The recommended sequence for doffing PPE was 1. Remove gloves, 2. Remove gown, 3. Exit the patient room, 4. Perform hand hygiene, 5. Remove face shield or goggles, 6. Remove and discard respirator, 7. Perform hand hygiene.