STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056259	A. BUILDING _____ B. WING _____	09/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHVINE POSTACUTE CARE	**446 ARROWOOD DR SANTA ROSA, CA 95407**

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 ensure the following infection prevention and control practices, when: 1. Staff donned and doffed Personal Protection Equipment (PPE) without consistent hand hygiene between each step. 2. The facility staff did not ensure staff had well stocked PPE stations with yellow isolation gowns, alcohol-based hand rub (ABHR), in sufficient number and within easy access of resident rooms. 3. Trash cans were not placed near resident's bedroom door, for staff to discard gowns and gloves before they exited, and gowns were place on back of resident bedroom doors, rather than front, requiring staff to enter potentially dirty rooms to get clean gowns and gloves. 4. Management did not provide aggressive staff monitoring that assured staff were consistent in their use of PPE. 5. Staff and residents entered and exited the facility wearing gowns and masks that were not removed and replaced before entering again, and staff did not consistently apply ABHR upon re-entrance. 6. Communally used activity supplies, (such as books, magazines, and games) were not cleaned between use, or provided to individual resident rooms for dedicated use by only one resident. Findings: During focused infection control observations on 8/27/20, between 1:15 p.m. and 4:30 p.m., the facility had a census of 48. Three of the 48 residents were positive for COVID 19 and were cohorted in a room located on the Garden Hall, room [ROOM NUMBER]. One Registered Nurse and one Certified Nursing Assistant were assigned as dedicated personnel to Residents 1, 2, and 3, and were the only staff wearing N-95 masks due to limited availability. A red tape across the floor indicated it was a red zone. Remaining rooms had two to four residents per room. Gloves were available in each resident room, but there were no ABHR dispensers or easy access PPE at each door. ABHR was not readily available to use between donning and doffing per best practice without walking between approximately 18 feet in the Garden Hall and approximately 31 feet for a dispenser in Rose Hall (only 2 dispensers on Rose Hall and one PPE cart stocked with blue plastic disposable gowns that staff complained were too hot compared to the preferred yellow disposable isolation gowns). Staff were observed wearing surgical masks, face shields or goggles according to their preference, and yellow disposable gowns. Some staff were wearing cloth gowns to protect their clothing. During demonstration of donning and doffing, staff did not consistently handwash or use ABHR between removing and putting on gloves, and touched hair or outside of goggles/face shields without using ABHR after. A single sink at a nursing station was used by staff to wash hands before walking down a hall to don PPE before entering a resident room. Resident rooms had bathrooms that were used by staff to wash hands prior to leaving resident rooms, with doffing of gloves occurring in resident bathrooms and used PPE being placed in trash cans placed near or in resident bathrooms, rather than at the resident's bedroom exit door per best practice. Multiple residents were seen sitting out in the hall, some with masks, some without. Observations included the following: At 1:15 PM, a staff member exited the facility in a yellow gown towards a parking lot and then returned into the facility wearing the gown without removing it prior to entrance. Two individuals sat outside the facility in a designated smoking area. One smoked and wore neither a gown nor mask. The other individual faced the smoker wearing a disposable gown and mask. At approximately 1:25 PM, the smoker entered the facility, bypassed the screening station, and staff standing there. The resident wore neither a gown or mask, did not use ABHR upon entrance, and staff did not offer either. At 2:30 PM, during a tour of Garden Hall, two Certified Nursing Assistants, (CNAs) came out of a resident room (22) wearing surgical masks, hair covers, and eye shields of choice (one with goggles, the other with a face shield). Gowns had been removed and replaced in trash can that was not near door exit, but near resident bathroom back in far corner of room. One PPE cart was left of bedroom door and contained blue plastic gowns that staff stated were too hot to wear, preferring yellow disposable gowns. When asked to demonstrate donning and doffing, one unnamed CNA walked across hall to room [ROOM NUMBER], entered room without a gown and from back of door retrieved a plastic bag containing a yellow disposable gown, explaining CNAs hung clean gowns on back of resident doors at beginning of their shifts for use. Resident rooms had disposable gloves in resident rooms, but no ABHR. Washing hands at resident bathroom sinks were encouraged prior to exit. Unnamed CNA did not use ABHR before and after removing gloves. Both CNAs touched hairnets and outside goggles to adjust without using ABHR or other hand hygiene before or after. There was no signage at each resident door indicating what precautions the resident was on and what PPE should be used. There was no signage identifying the unit as PUI (Persons Under Investigation) or a yellow zone, despite residents having been exposed to COVID 19 by positive staff. Both CNAs indicated they wiped their goggle/face shield after usage with a bleach wipe, but wore the same surgical mask and goggle/face shield for their entire shift, At 2:40 PM, two residents sat in an alcove next to the nursing station, there was a small bookcase with books, magazines and games. When asked, nursing staff at nursing station could not state how or if books, magazines, and games were wiped before and after use by residents. Activity Director stated residents did not currently use these items. At 2:53 PM, a resident took a magazine and sat flipping through its pages. At 2:43 PM, during a tour of Rose Hall (10 resident rooms), only two ABHR dispensers were on entire hall and one PPE cart containing only blue plastic gowns. A random screening of three bedrooms (1, 3 and 4) indicated staff had not placed any clean disposable yellow gowns on back, or front, of resident doors. Only gloves were available inside patient rooms, no ABHR as an alternative to handwashing, and trash cans were at resident bathrooms rather than at bedroom exit. There was no signage at each resident door indicating what precautions the resident was on and what PPE should be used. There was no signage identifying the unit as PUI, although in an interview at 1:50 p.m., Administrator stated three COVID positive residents were in a red zone, and remaining 45 residents were all to be treated as PUI and in yellow zones. At 2:48 PM, Certified Nursing Assistant B (CNA-B), demonstrated donning and doffing using a blue plastic gown from the one PPE cart on the unit (Rose Hall). CNA-B stated he used PPE from carts in hall. CNA-B had difficulty opening the gown up and donning it, requiring reminder where to place thumbs, and did not use any hand hygiene/ABHR prior to putting on gloves and after removing them. CNA-B wore a surgical mask but did not wear either goggles or face shield. At 3:12 PM, a random check of three resident rooms (18, 21, and 23) indicated there were no yellow disposable gowns hung on hooks on back of resident doors as described earlier. room [ROOM NUMBER] had a cloth gown hanging on back of one door. Staff were unable to explain if it was clean or dirty. A staff interview on 8/27/20 at 1:15 PM, with Registered Nurse A, indicated he wore a yellow disposable isolation gown, .when I come in and then after that I wear it all day long. I don't have luxury to change it on every room or patient as we don't have enough gowns. I wish we had that luxury. During an interview on 8/27/20, at 1:50 PM, Administrator stated it was not acceptable for staff or residents to exit and enter the facility without changing gowns, or masks, and agreed shared items (e.g. books, magazines, communally used items) should be cleaned between use. Administrator stated that the facility had plenty of gowns but that facility policy was one gown per room rather than per resident (rooms averaged two to four residents). At approximately 2:40 PM, Administrator introduced Infection Control Preventionist and other management standing near facility entrance and nursing station. Although invited to participate in facility tour, ICP chose not to and were not monitoring staff for donning and doffing or for consistent practice using ABHR between donning and doffing tasks. Review of documentation indicated handwashing emphasis. Administrator stated he preferred handwashing to use of ABHR but had recently ordered dispensers that would be put up outside resident rooms. Administrator stated Rose Hall should have had some hand-pump ABHR available in hall and didn't

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) know why it was not available. Glove boxes were in patient rooms and some were also loosely sitting on outside hall railings. A record review of facility policies for hand hygiene and donning and doffing indicated the following: 1. COVID-19 Personal Protective Equipment (PPE) for Healthcare Personnel (HCP), dated 4/1/20, indicated N95 or higher respirator was preferred, that staff performed hand hygiene prior to putting on isolation gowns, before putting on gloves, and was all done prior to entering resident rooms. Removal or doffing of PPE included removing gowns and gloves prior to exiting patient room, performing hand hygiene after exiting room, and after removing facemask and face shields or goggles. Staff should not touch front of face shield or goggles. Staff should perform hand hygiene after removing respirator/facemask and before putting it on again if reused. 2. Hand Hygiene, undated, indicated staff washed hands 20-30 seconds between tasks. 3. Infection Control Guidelines for All Nursing Procedures, dated 1/2018, indicated staff in most situations, unless hands are visibly soiled, the preferred method of hand hygiene is ABHR before donning gloves and after moving gloves and after contact with objects in immediate vicinity of resident. On 9/4/20 at 4:41 PM, the facility provided no requested policies and procedures for PUI infection control, including whether doors should be open or closed, or what PPE staff should wear. The facility did not provide a policy or procedure for their system for stocking PPE on the floor, or for their gown and faceshield use.