STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055635	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BRANDEL MANOR	**1801 N. OLIVE AVENUE TURLOCK, CA 95382**

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 and maintain a safe environment with an effective infection prevention and control program for the prevention of a [MEDICAL CONDITION] (COVID-19- a contagious serious respiratory infection transmitted from person to person) transmission when: 1. Three of eight sampled employees (Licensed Vocational Nurse (LVN) 1, Certified Nursing Assistant (CNA) 1 and CNA 2) did not wear personal protective equipment (PPE-equipment used to protect self and others from contagious infections) while in the PUI (Patients Under Investigation-person exposed to someone infected with COVID-19 or who is symptomatic for COVID-19) units in accordance to recommendations from the Centers for Disease Control (CDC). 2. Sixteen of 16 PUI room doors inside the PUI yellow zone, and four of four PUI room doors in the orange zone remained open and not closed in accordance to recommendations from the CDC. 3. A box fan was used for ventilation inside the dedicated nursing station of the COVID-19 unit (red zone). These practices potentially placed the residents and staff at risk for the spread and transmission of COVID-19, complications from COVID -19 and death. Findings: 1. During an interview on 7/7/2020, at 10:27 a.m., with the Administrator (ADM), the ADM stated there were four different zones with cohorts (group of residents who are infected with the same infection or meet the same criteria) of residents. The ADM stated the zone depended on the COVID-19 status. The ADM stated the green zone was designated for those residents who were negative for COVID-19. The ADM stated residents in the yellow zone were for residents considered PUI and were under quarantine (time used to keep someone exposed to COVID-19 away from others). The yellow zone included hospital admissions, readmission and residents who received [MEDICAL TREATMENT] (treatment to filter/clean the blood). The ADM stated the residents in the PUI section would remain in the PUI Unit until their individual COVID-19 status was known. The ADM stated residents in the orange zone were for residents considered PUI's after an exposure from having a COVID-19 positive roommate. The ADM stated the red zone was designated for residents who were positive for COVID-19. During a concurrent observation and interview on 7/7/2020, at 2:14 p.m., with CNA 1, CNA 1 exited a PUI room in the orange zone with an N-95 respirator (particulate filtering facepiece) placed underneath her nose. CNA 1 stated the residents in the PUI unit (orange zone and yellow zone) were considered patients under investigation for COVID-19. CNA 1 stated the residents in the orange zone were under investigation following an exposure from COVID-19 positive roommates. CNA 1 stated she would put on an N-95 respirator, a gown and gloves each time she entered a PUI room in the orange zone. CNA 1 adjusted her N-95 respirator multiple times while she spoke. CNA 1 stated her N-95 respirator did not fit her correctly. CNA 1 stated if she were sick, she could potentially transmit COVID-19 to the residents, because her respirator did not fit correctly. CNA 1 stated in order for the N-95 respirator to be effective, it needed to form to the face and cover the nose and mouth completely. CNA 1 stated COVID-19 was spread in the air/droplets that went into the respiratory tract. During a concurrent observation and interview on 7/7/2020, at 2:15 p.m., with LVN 1, in the yellow zone, LVN 1 did not wear a face shield. LVN 1 stated the PPE she wore in the yellow zone consisted of a gown, a mask and a face shield. LVN 1 stated she did not have a face shield on while in the PUI unit. During a concurrent observation and interview on 7/7/2020, at 2:35 p.m., with CNA 2, in the hallway of the PUI unit, CNA 2 wore a surgical mask over the top of the N-95 respirator. CNA 2 stated the staff who cared for residents in the PUI unit yellow zone did not wear face shields or gowns when resident care was provided. CNA 2 stated gowns and face shields were worn in the COVID-19 unit (red zone). CNA 2 stated when a resident was known to be COVID-19 positive; the staff would have to wear a face shield. CNA 2 stated COVID-19 was spread through coughing, sneezing and was airborne. CNA 2 stated the residents in the yellow zone were potentially positive for COVID-19 but remained under investigation. During an interview on 7/7/2020, at 5:28 p.m., with LVN 1, LVN 1 stated staff who worked in the yellow zone did not wear gowns or face shield while providing care to the residents. LVN 1 stated the yellow zone unit housed PUI's, which could potentially have COVID-19. LVN 1 stated the residents in the yellow zone were considered PUI's because they were new admits, received [MEDICAL TREATMENT] and left the facility frequently. LVN 1 stated the staff in the PUI units were required the recommended PPE. During an interview on 7/7/2020, at 5:40 p.m., with the Director of staff development (DSD), the DSD stated the staff in the yellow zone were required to wear a surgical mask and gloves. The DSD stated the staff in the yellow zone did not need to wear an N-95 respirator, face shield or gown. The DSD stated the staff in the COVID-19 unit were required to wear full PPE, which was an N-95 respirator, face shield, gown and gloves. During a concurrent interview and record review on 7/7/20, at 6:10 p.m., with the DSD, the DSD reviewed the professional reference from the CDC titled, Responding to Coronavirus (COVID-19) in Nursing Homes, dated April 30, 2020 which indicated, .All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N-95 or higher level respirator . eye protection . gloves and gown . After reviewing the CDC guidelines, the DSD stated, the staff in the yellow zone should be wearing gowns, gloves, N-95 mask and a face shield. During a concurrent interview on 7/7/2020, at 6:40 p.m., with the Administrator (ADM), DSD, ADON and IDON, the DSD stated, the facility did not follow the CDC recommendations for PPE worn in the Yellow Zone. During a professional reference, review retrieved on 7/23/2020, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html dated 7/15/2020, titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) indicated, Pandemic Implement Universal Use of Personal Protective Equipment. HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic (without symptoms) or pre-symptomatic patients with [DIAGNOSES REDACTED]-CoV-2 infection. If [DIAGNOSES REDACTED]-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). They should also: Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters. For HCP working in areas with minimal to no community transmission, HCP should continue to adhere to Standard and Transmission-Based Precautions, including use of eye protection and/or an N-95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses. Universal use of a facemask for source control is recommended for HCP . During a professional reference, review retrieved on 7/23/2020, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html dated 7/15/2020, titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) indicated, Personal Protective Equipment HCP who enter the room of a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N-95 or equivalent or higher-level respirator (or facemask if a respirator is not available), gown, gloves, and eye protection. When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important and the care of patients with pathogens requiring Airborne Precautions (e.g., [MEDICAL CONDITION], [DIAGNOSES REDACTED], [MEDICATION NAME]). Information about the recommended duration of Transmission-Based Precautions is available in the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of hospitalized Patients with COVID-19. 2. During an observation on 7/7/2020, at 2:31 p.m., in the PUI unit known as the yellow zone 16 resident bedroom

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) doors remained open. During a concurrent observation and interview on 7/7/2020, at 2:14 p.m., with CNA 1, in the orange zone hallway, four resident bedroom doors remained open. CNA 1 stated the resident bedroom doors would remain open in the PUI orange zone unit unless a resident requested their door to be closed. During a concurrent observation and interview on 7/7/2020, at 2:35 p.m., with CNA 2, there were 16 bedroom doors open in the yellow PUI zone, and 4 open bedroom doors in the orange PUI zone. During a concurrent observation and interview on 7/7/20, at 5:28 p.m., with LVN 1, in the yellow zone, LVN 1 stated all 16 bedroom doors remained open. LVN 1 stated it was a common practice to leave the bedroom doors open. During an interview on 7/7/2020, at 6:40 p.m., with the DSD, the DSD stated bedroom doors inside the PUI zones needed to be closed because COVID-19 was virus that could spread by way of airborne particles. During a professional reference review retrieved on 7/23/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html dated 7/15/2020 titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic indicated, .2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection . Patient Placement If admitted , place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection .with the door closed. 3. During a concurrent observation and interview on 7/9/2020, at 11:40 a.m., with CNA 3 in the red zone hallway, pointed out a box fan that was turned on in the dedicated nursing station. CNA 3 stated the use of the fan inside of the red zone could cause the spread of COVID-19 droplets. CNA 3 stated the fan was usually kept on to provide additional ventilation. During an interview on 7/9/2020, at 5:25 p.m., with the Interim Director of Nursing (IDON), the IDON stated the fan should not be on in the red zone because COVID-19 infection could be easily spread in the air.