STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056026	A. BUILDING _____ B. WING _____	04/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EMPRESS CARE CENTER, LLC	1299 S. BASCOM AVENUE SAN JOSE, CA 95128

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)
E 0024 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Establish policies and procedures for volunteers.** Based on interview and record review, the facility failed to develop emergency preparedness policies and procedures that addressed the use of volunteers or other emergency staffing strategies including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Findings include: A review of the facility policy titled, Staffing Expansion for COVID19 on 4/2/20, revealed plans to consider calling staffing registries and other facilities for assistance in the event the facility was unable to staff direct caregivers. However, the plan did not address the requirement for use of volunteers or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. During an interview on 4/2/20 at 4:20 p.m., the Administrator stated he reviewed the policy and the regulation and confirmed the facility policy did not include the required components of the regulation in the event the facility had to implement the policy for an emergency.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review, the facility failed to keep food off the floor; failed to ensure the sanitization level in the cleaning buckets was maintained; and failed to document sanitization logs according to facility policy. These failures had the potential to contaminate food and food preparation surfaces which could result in facility wide food borne illness. A. During a concurrent brief kitchen observation and interview with the Dietary Manager (DM) on 4/2/20 at 9:00AM, two boxes of produce (lettuce) were found on the floor beside the hand sink. The DM stated the food had just been delivered and was in the process of being put away. The DM stated he knows food is never to be stored on the floor and he would ensure that even during delivery he would place food on something six inches off the floor as per facility policy. B. Review of the Quaternary Ammonium (disinfectant chemical) Log revealed instructions for staff to test the ammonium concentration in the sanitizer buckets using the proper strips and record the concentration reading on the form below, once in the AM and once in PM. The log also showed the concentration readings should be at least 200 parts per million and that staff were to alert the Director if ammonium levels were below the minimum. During continued observation and interview on 4/20/20 at 9:00AM, the DM tested the concentration of the sanitization bucket next to the dish machine and the reading was 100. The DM stated the level was supposed to be 200. The bucket was emptied and refreshed with new sanitizer and a concentration of 100 was again obtained. However, after a third attempt, the concentration was 200. The DM stated he would make sure the chemicals were calibrated properly and that staff knew how and when to change the buckets to optimize disinfection of the kitchen surfaces. During further review of the Quaternary Ammonium Logs and concurrent interview with the DM, the logs revealed staff failed to document the concentration readings 21 out of 62 times in March 2020 and 2 of 2 times in April 2020. Additional review of the logs revealed that when staff documented the readings, the concentration was always 200. The DM acknowledged staff were not always documenting the readings and that staff were supposed to refresh the buckets with new sanitizer and water every 4 hours and/or when needed, such as when the concentration was below 200. The DM stated he would review the policy with the kitchen staff.
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: A. Implement appropriate transmission-based precautions (TBP) that included signage and supplies for the specific personal protective equipment (PPE) outside of the resident's room; B. Implement outcome surveillance to ensure the facility knew how many residents showed signs and symptoms related to the novel coronavirus; and failed to C. Implement process surveillance to ensure staff were monitored for correct implementation of infection control policies. Findings include: According to the Centers for Disease Control and Prevention (CDC), [MEDICAL CONDITION] causing the novel coronavirus disease has been labelled COVID-19. A. During an interview on 4/2/20 at 8:30AM, the Infection Preventionist (IP) stated she had one resident (R1) on contact precautions for a [MEDICAL CONDITION]-resistant Staphylococcus Aureus (MRSA) bacterial infection in a leg wound and one resident (R2) on observation for fourteen days because he returned from the hospital with pneumonia but a negative COVID-19 test result. During an initial tour of the facility at approximately 10:00AM, there was no signage or supplies for the specific PPE outside of R1's or R2's rooms. During a concurrent observation and interview on 4/2/20 at 10:51AM, Certified Nurse Aide (CNA) 1 was observed outside of R2's room. CNA 1 stated R2 was on isolation because he had recently returned from the hospital. CNA 1 stated there was no signage or PPE outside of the room but that staff knew to wear a mask in the room and to put on gloves and a gown before going into the room if they would be providing care. CNA 1 stated staff were to remove the gown and gloves inside the room and then wash their hands as soon as they leave the room. CNA 1 stated she only changed her mask if it was soiled or she touched the outside of the mask. During an interview on 4/2/20 at 11:00AM, the IP stated R1 had been on contact precautions since 3/23/20 when he was diagnosed with [REDACTED]. The IP acknowledged she had not put up the signage until today. The IP said she had had the PPE supplies outside of the room but it had been taken away in the morning to be restocked. The IP stated she only had one bin and did not know if the facility was ordering more bins. The IP stated she would make sure the signage and the bins were implemented for every TBP in the facility. During a concurrent observation and interview on 4/2/20 at 11:15AM, Licensed Vocational Nurse (LVN) 2 was observed outside of R1's room. LVN 2 stated R1 was on contact precautions for about a week and that she obtained PPE supplies from the nursing station. LVN 2 stated she put on a gown and gloves before going into the room and disposed of the gown and gloves inside the room before coming out. LVN 2 stated she immediately cleaned her hands outside the room using the wall hand sanitizer. LVN 2 stated a bin of supplies used to be outside the room but now she got supplies from the nursing station. LVN 2 stated she did not know why there had been no signs outside the room indicating the type of TBP and PPE that was required. Review of R1's record revealed daily documentation in the nursing notes from 3/24/20 to 4/2/20 that R1 was on contact precautions. Review of R1's roommates, R3 and R4, confirmed they had been moved to another room on 3/24/20. B. During an interview on 4/2/20 at 11:00AM, the IP stated there had been one resident (R2) who had a fever and respiratory signs and symptoms related to COVID-19. However, during an initial tour of the facility at approximately 10:00AM, another resident (R5) was heard coughing inside his room. The door was shut and the name plate identified that only one resident lived in the room. Record review on 4/2/20, revealed R2 was hospitalized with a fever which started 3/22/20; and R5 had a cough that started on 3/27/20. Additional record review for R1 and R3 revealed R1 had a cough between 3/15 and 3/24; and R3 had a cough between 3/15 and 3/25. However, the IP did not identify R1, R3 or R5 as having respiratory symptoms related to COVID-19 which includes fever, cough and shortness of breath. During an interview on 4/2/20 at 4:20PM, the Administrator stated he

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 create an outcome surveillance tracking log with all the residents who have had a fever or other respiratory signs and symptoms related to COVID-19. The Influenza and ILI (influenza like illness) Outbreak Line Listing for Healthcare Facilities Residents, was provided on 4/3/20 at 8:52AM and identified seven residents. During continued interview and record review with the Administrator on 4/2/20 at 4:20PM, the Administrator stated the facility had not followed the monitoring of residents protocol documented in the County of Santa Clara Public Health Department Long-Term Care Facilities COVID-19 Toolkit which states, If a resident has a fever or new symptoms of a respiratory illness, the facility should: - Institute appropriate infection prevention and control measures, including: - have the patient immediately wear a facemask - isolate the patient to a single room - use appropriate PPE with contact and droplet precautions - consult with a medical provider regarding the need to transfer residents to a higher level or care and/or COVID-19 testing - Notify the Santa Clara Public Health Department at During an interview on 4/3/20 at 8:39AM, the IP stated she had not been completing outcome surveillance for residents who had only developed a cough. The IP stated the attending physicians had been notified of the coughs and they had prescribed cough medicine and asked staff to call if the residents had developed a fever. The IP stated she had not followed the Toolkit and had not isolated the resident, had not implemented contact and droplet precautions and had not notified the public health department. The IP stated she would make sure to implement the protocol immediately. C. Review of the Infection Control Surveillance documentation revealed blank process surveillance observation forms related to hand hygiene, COVID-19 surveillance, transmission based precaution isolation rooms, personal protective equipment and environmental cleaning. However, there was no evidence that any audits were completed to ensure staff were being monitored for compliance to infection control policies. During an interview on 4/2/20 at 11:00AM, the IP confirmed she had not been monitoring staff for compliance with hand hygiene, COVID-19 surveillance, transmission based precaution isolation rooms, personal protective equipment or environmental cleaning to ensure infection control policies were implemented correctly. The IP stated she would begin monitoring staff compliance and document her audits using the observation forms she had as part of the infection control surveillance program.