STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555710	A. BUILDING _____ B. WING _____	07/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE HEALTH SERVICES - TICE VALLEY	1975 TICE VALLEY BLVD. WALNUT CREEK, CA 94595

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 -** Immediate jeopardy **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 records review, the facility failed to follow infection control practices to prevent spread of infection in the facility during a novel Coronavirus Disease (COVID-19 - a mild to severe respiratory (lung) illness) outbreak (an occurrence of disease greater than expected at a particular time and place) when the following were observed: 1. The facility's surveillance system (monitoring of the spread of disease to establish patterns of disease progression) including mapping (tracking tool used to identify outbreaks and for disease prevention and control), and tracking (summary information of persons who may be associated with an outbreak) were not completed to accurately monitor progression of COVID-19 outbreak in the facility that resulted in failure to properly cohort residents who tested positive with COVID-19. 2. The facility did not assign dedicated staff for caring for COVID-19 residents and Persons Under Investigation (PUI - residents being isolated and observed for Covid 19 symptoms and waiting for Covid 19 testing results). 3. Two facility staff members did not follow guidelines for donning and doffing of PPE when entering and exiting COVID-19 designated units. 4. COVID-19 positive residents were roomed with PUI residents and multiple doors of resident bedrooms were left open. These cumulative failures to follow transmission-based precautions resulted in widespread outbreak of COVID-19 cases at the facility including 54 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, and 54), and 33 staff members (Certified Nursing Assistants (CNA) 1, 2 , 3 ,4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, Registered Nurse (RN) 1, 2, 3, 4, 5, 6, Licensed Vocational Nurse (LVN) 1, 2, 3, 4, 5, Housekeeping (HSK) 2 , 3, Rehabilitation Staff 1, 2, Unit Manager (UM), and Admission Coordinator (AC)) who worked at the facility. Two residents died (Resident 2 and 32) in the facility of COVID 19. The Administrator, Director of Nursing (DON), Infection Preventionist (IP), and Housekeeping Supervisor (HS) were verbally notified of the Immediate Jeopardy (IJ) on [DATE] at 3:37 p.m. The facility failed to implement infection control interventions that would prevent the spread of COVID-19. Through observation, interviews with the staff members and record reviews of the facility's documents, the facility showed they initiated the plan of action through in-services of employees regarding infection control. The IJ was abated during an on-site visit on [DATE] at 2:11 p.m. Findings: 1. During an interview with the Administrator on [DATE] at 10:10 a.m., the Administrator stated the facility had a total of 54 cumulative cases of residents and 32 cumulative cases of staff tested positive for COVID-19 as of [DATE]. Of the 54 total cumulative residents who tested positive with COVID-19, 47 residents were in the facility, five residents (Residents 1, 12, 13, 18 and 53) were transferred to the acute hospital for further treatment, and two residents (Resident 2 and 32) expired at the facility due to COVID-19 During an interview and record review with the Infection Preventionist on [DATE] at 11:00 a.m., the IP was unable to show mapping was completed. The IP was not able to provide the number of residents who were PUI or positive for COVID-19. The spreadsheet did not include exhibited symptoms of residents who were symptomatic, nor did it list the residents who were roommates of residents who tested positive with COVID-19. A review of the facility's Infection Control Manual titled, Surveillance dated ,[DATE] indicated, Infection Detail Report: This report provides a comprehensive look at the patients who have infections, their room numbers, the onset date, admitted , whether it is an Healthcare Associated Infections (HAI) or Community Acquired (CA), types of infection, symptoms . When reviewing this report, it is important to look at each column to identify trends and commonalities. Look at the room number to see if infections are within close proximity, on the same hall, in the same room or on the same unit .Look at the type of precautions implemented . Identify trends. Further review of the untitled and undated spreadsheet revealed a cumulative total of 54 residents were tested positive with COVID-19 from [DATE] through [DATE]. Of the 54 total cumulative positive cases, five residents (Residents 1, 12, 13, 18 and 53) were sent out to acute care hospital, one resident (Resident 14) was transferred to non-acute care facility, and two expired (Resident 2 and 32) at the facility. The spreadsheet did not indicate the dates of transfer for Residents 1, 12, 13, 18 and 53), nor the date when Resident 2 and 32 expired. During a record review of an undated facility document titled, Employee Tracker the reflected 31 facility staff (Certified Nursing Assistants (CNA) 1, 2 , 3 ,4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, Registered Nurse (RN) 1, 2, 3, 4, Licensed Vocational Nurse (LVN) 1, 2, 3, 4, 5, Housekeeping (HSK) 2 , 3, Rehabilitation Staff 1, 2, Unit Manager (UM), and Admission Coordinator (AC)) were tested positive from COVID-19 between the dates of [DATE] through [DATE]. During a concurrent interview with IP on [DATE] at 11 a.m., IP stated the document did not include the cumulative total of 33 facility staff. The employee tracker did not include RN 5 and 6 who were reported COVID-19 positive as of [DATE]. During an interview with the DON on [DATE] at 11:00 a.m., and review of the facility's document titled, Daily Staffing record dated [DATE] through [DATE], the staffing record revealed licensed staff were assigned to care for residents in wings of COVID 19 positive residents, PUI's, and COVID 19 negative residents. The DON stated staff who tested positive for COVID-19 were providing care to COVID-19 positive, PUI and COVID-negative units in the facility. A review of the Centers for Disease Control and Prevention (CDC) published guidelines titled Preparing for COVID-19 in Nursing Homes, dated [DATE] indicated, Background: Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 .As demonstrated by the COVID-19 pandemic, a strong infection and control program is critical to protect both residents and health care personnel. 2. During a concurrent interview and record review with the DON and Regional Director of Operations (RDO) on [DATE] at 11:45 A.M., the DON explained Building A and Building B, each have COVID-19 units. During an observation and facility floor plan review on [DATE] at 12 noon with DON and RDO, a resident (Resident 51) who tested positive for COVID-19 on [DATE] and a PUI resident (Resident 59) were sharing a room , and a resident (Resident 50) who tested negative for COVID-19 and a PUI resident (Resident 56) were sharing a room. According to the facility's undated policy and procedure titled, Designation of Space Antechamber or COVID-19 Airborne Isolation, Patients with confirmed [DIAGNOSES REDACTED]. During an observation outside the facility main entrance on [DATE] at 10:40 a.m., Occupational Therapist 1 (OT 1) who was wearing PPE including; N95 mask, face shield, gown, gloves, and shoe coverings, exited from the building using an outside emergency door in Building B wing 3. OT 1 walked across the parking lot, entered a car, and proceeded to walk back inside the building using the same doorway she exited. During the facility tour observation and interview with DON on [DATE] at 12:00 p.m., Building A and Building B were observed each with COVID-19 units. DON stated COVID-19 hallways each have antechamber units covered in plastic barriers with zipper. The first plastic barrier serves as the entry and exit where staff don and doff their PPE, while the second plastic barrier was an entry and exit to the wing of the COVID-19 units. DON stated the emergency exit doors in each of the COVID-19 units should not be used to enter or exit the building. During an observation on [DATE] at 12:30 p.m., Housekeeper 1 (HSK 1) was observed entering Building B from the outside parking lot using the emergency exit door leading to the COVID-19 unit hallway. HSK 1 did not perform hand hygiene and did not wear PPE upon entry to the COVID-19 unit hallway. HSK 1 walked down the hallway passing by 12 resident rooms housing COVID-19 positive residents, HSK 1 entered the plastic barrier to the antechamber donning and doffing area. A review of the facility's undated policy and procedure titled, Designation of Space Antechamber

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) or COVID-19 Airborne Isolation Unit (CAIU) indicated Personnel need to wash their hands before touching zipper wall and entering antechamber, Personnel need to enter chamber and securely close zipper, Personnel are to wash hands after closing first barrier wall zipper, Don PPE. Enter unit from antechamber. Securely close zipper on second barrier wall after leaving antechamber .When preparing to leave the unit, perform hand hygiene before touching zipper to first barrier wall entering antechamber. Securely zip barrier wall closed. Doff PPE and wash hands. Exit the antechamber through the second zipped wall. Securely zip barrier wall closed. Perform hand hygiene before proceeding to any other area of the facility. 4. During an observation and interview with the DON on [DATE] at 12:00 p.m., rooms [ROOM NUMBERS] doors were left open. DON immediately closed the doors in room [ROOM NUMBER], and room [ROOM NUMBER]. DON stated the rooms of residents who tested positive for COVID-19, and residents who were considered PUI's should always have their door closed. During an observation and interview with Staff 2 on [DATE] at 12:30 p.m. in Building B emergency exit door, HSK 1 parked the housekeeping cart in front of room [ROOM NUMBER] adjacent to room [ROOM NUMBER]. Both rooms were observed to have left open. A review of the CDC's undated guidance titled, Transmission-Based Precaution indicated In settings where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patients and placing the patients in private room with the door closed will reduce the likelihood of airborne transmission.