STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555792	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNNYVALE POST-ACUTE CENTER	1291 S BERNARDO AVENUE SUNNYVALE, CA 94087

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 follow the policy or procedure on COVID-19 (Coronavirus disease is an infectious disease, spread from person to person via respiratory droplets) infection control practices related to the care of residents when: 1. One of the facility's observation unit/transition unit (OU/TU, refers to a wing/area of the facility created to keep residents for a 14-day observation of any signs and symptoms of coronavirus) was not separated by a physical barrier that prevented easy and/or open access to any resident, staff or visitor; and there were no transmission based precautions (TBP, isolation precautions to help prevent spread and transmission of illness/disease) signage placed in the residents' doors. 2. Universal mask requirement for residents who were outside of their rooms were not followed as part of the universal source control measures. 3. Two paramedics who came to pick up one resident for [MEDICAL TREATMENT] did not wear N-95 masks (an N95 respirator is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles that blocks at least 95 percent of very small (0.3 micron) test particles) when they entered the resident's room inside the OU/TU. 4. The facility's mitigation plan to provide designated area to chart and monitor patients, to don and doff PPE, separate medication storage and preparation area, separate clean supply area in their OU/TU were not followed. 5. Temperature and COVID-19 symptoms screening of two surveyors who were granted access to enter facility were not done. 6. One staff did not follow the correct handwashing procedure after resident care. 7. Three staff did not remove or disinfect their used face shields, a Personal Protective Equipment (PPE, protective equipment used when caring for patients to prevent the spread of infectious diseases) after resident care prior to exiting out of the OU/TU. 8. One staff did not remove and properly store his used N-95 mask before exiting out of the OU/TU. 9. One visiting health care personnel (HCP) did not change gloves between three resident assessments and treatments, and after touching a dirty area; placed a contaminated box of tissue paper with the clean supplies and instrument being used for residents' treatment. 10. Symptomatic and/or suspected COVID residents' monitoring of vital signs (temperature, respiratory rate and oxygen saturation) twice on the day shift and twice on the evening shift were not done. 11. Two staff did not properly wear their facemasks. 12. A licensed nurse did not wear a face shield in the observation unit while providing care. 13. A staff conveyed a different approach in disinfecting a used face shield. 14. Dedicated PPE storage area did not have a complete supply of PPE. These failures had the potential for the spread and transmission of infection to patients, staff and visitors. Findings: 1. During an observation on 7/21/2020 at 9:05 a.m. with the DSD, one wing near the entrance door was designated as one of the facility's OU/TU called Ortho wing. No physical barrier was installed. The door was wide open and no signage indicated the area was used for the eight residents under observation. The residents' rooms had no TBP, which should have indicated the type of isolation precautions required. During a concurrent interview, the DSD stated the door should have been closed to separate the OU/TU from the other part of the resident's unit, or a physical barrier should have been installed with a signage that indicated the area was dedicated for residents under observation. The signage could provide caution to staff, visitors and residents before entering the area. 2. During the facility rounds, and multiple observations on 7/21/2020 at 9:16 a.m., 9:18 a.m., 9:27 a.m., 9:30 a.m., 9:35 a.m., and 10:12 a.m.,with the director of staff development (DSD), there were six residents not wearing their masks/face coverings. During an interview on 7/21/2020 at 9:20 a.m., the DSD stated staff should have reminded residents to wear their masks when out of their rooms to help prevent the spread of coronavirus. 3. During an observation on 7/21/2020 at 10:00 a.m., two paramedics, without N-95 masks, entered Resident 1's room in the OU/TU to pick him up for [MEDICAL TREATMENT] treatment. During an interview on 7/21/2020 at 10:05 a.m., both paramedics stated they asked prior permission from one licensed staff before they entered the OU, but were not given instructions to wear N-95 masks nor informed of the required TBP. 4. During an observation, concurrent interview and record review on 7/21/2020 at 11:35 a.m., with the DSD, the facility's two designated OU/TU wings had no dedicated space for staff to don and doff PPE's, area to chart and monitor residents, and separate clean and dirty areas. 5. During the surveyors' entry to the facility on [DATE] at 7:35 a.m., registered nurse A (RN A) came to the door and ushered them inside without checking their temperature and prior screening for COVID-19 signs and symptoms. During an interview on 7/22/2020 at 7:36 a.m., with the DSD, he stated whoever opened the door was responsible for screening visitors and/or staff. 6. During an observation with the DSD present on 7/22/2020 at 8:05 a.m., certified nursing assistant B (CNA B) washed his hands less than 20 seconds after doffing his gown, mask and gloves. 7. During an observation on 7/21/2020 at 11:35 a.m., registered nurse C (RN C) was seen with the same used face shield when she passed medications in the OU/TU and continued to pass medications to her other assigned residents in the green/clean unit (GU, space/unit where residents who had no COVID-19 symptoms and were not on observation are located). During a concurrent interview with RN C, she confirmed she did not disinfect nor change the same face shield she used in the OU when she went to the GU. During an observation and concurrent interview on 7/22/2020 at 11:00 a.m., registered nurse D (RN D) after finishing her medication pass in the OU/TU, continued to perform medication pass to their green/clean unit without disinfecting or changing/removing her used face shield. RN D confirmed the observation. During an observation and concurrent interview on 7/22/2020 at 11:30 a.m., CNA B did not remove/change or disinfect his face shield when he went out of the OU/TU to return the dietary cart to the kitchen. CNA B confirmed the observation in the presence of the IP. During an interview on 7/21/2020 at 12:40 p.m., both the DSD and the IP stated staff should start in the GU before the OU as much as possible. Both also stated, when staff leave the OU, they have to change or remove their face shields before moving around the clean zone of the facility, or disinfect the 8. During an observation on 7/22/2020 at 8:40 a.m., CNA B did not remove his N-95 mask when he went out of the OU/TU. During an interview on 7/22/2020 at 8:50 a.m., both CNA B and the DSD stated N-95 masks should be removed and hung on the provided hook and changed to a facemask when leaving the observation unit to prevent the spread of infection. 9. During an observation on 7/22/2020 at 8:56 a.m., visiting physician assistant C (PA-C) assessed and provided treatment to three residents in rooms 10-A, 10-B and 11-A without changing his gloves in between residents' care. A box of tissue paper fell on the floor and PA-C put it back on the tray table, together with the instruments and clean gauze that were on the tray table lined with disposable chucks. PA-C validated the observation in the presence of the director of nursing (DON). PA-C stated, I got frazzled that's why I forgot to change my gloves. During an interview on 7/22/2020 at 9:00 a.m., the DON stated PA-C should not have placed the contaminated box of tissue paper with the supplies he used to treat and assess his residents. The DON also stated this was an infection control issue. 10. During an interview and concurrent record review on 7/22/2020 at 1:40 p.m., the DSD and infection preventionist (IP) reviewed the facility's mitigation plan, and resident's vital signs report that indicated, the residents' vital signs and assessment of COVID signs and symptoms were not done twice during day and twice during evening shift as indicated in their mitigation plan. Both staff confirmed, their mitigation plan was not followed. 11. During an observation with the DSD on 7/22/2020 at 7:50 a.m., laundry person E (LP E) wore her facemask which covered the oral but not the nasal region. LP E stated the facemask did not fit her. The DSD stated LP E should properly wear her

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) facemask by covering her nose. During an observation on 7/22/2020 at 8:50 a.m., kitchen aide F (KA F) was inside the kitchen and her facemask covered the oral but not the nasal region. KA F stated she could not breathe if the facemask was covering her nose. 12. During an observation and concurrent interview with RN C on 7/22/2020 at 8:30 a.m., RN C was inside room [ROOM NUMBER] with no face shield. RN C stated she gave medication to the resident in B bed and confirmed she forgot to put on the face shield. 13. During an observation and concurrent interview with CNA G on 7/22/2020 at 8:40 a.m., CNA G was wearing a face shield. When asked how to clean the face shield after use, CNA G stated she cleaned the face shield with soap and water. During a follow-up interview with the DSD, he stated after the face shield is used it should be cleaned with an alcohol-based solution. During an observation and concurrent interview with the IP on 7/22/2020 at 12:00 p.m., PPE storage located in the central supply room was inspected. There were gowns but no gloves, masks, face shield available. According to the IP, during their QAPI meeting on 7/15/2020, the plan was to store all their PPE in the central supply room so that all staffs would have access in case of immediate need 24 hours a day. According to CDC Guidelines, How to Wear Masks updated July 6, 2020, indicated Wear your Mask Correctly by .put it over your nose and mouth and secure it under your chin, try to fit it snugly against the sides of your face, make sure you can breathe easily. According to CDC Guidelines Selected Options for Reprocessing Eye Protection, indicated to adhere to recommended manufacturer instructions for cleaning and disinfection According to CDC Guidelines, .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown.depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.