STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHERWOOD OAKS HEALTH CENTER	**130 DANA STREET FORT BRAGG, CA 95437**

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** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to demonstrate the appropriate removal and discarding of a PPE (Personal Protective Equipment - works as a barrier between an individual's skin, mouth, nose, or eyes and [MEDICAL CONDITION] and bacterial infections), when Certified Nursing Assistant (CNA) A did not remove and discard her protective gown prior to exiting Resident 1's room, where Resident 1 was quarantined due to being a PUI (Person Under Investigation for possible COVID-19; Coronavirus Disease of 2019 - [MEDICAL CONDITION] identified as the cause of an outbreak of respiratory illness). This failure had the potential for the transmission of COVID-19 infection to other residents of the facility. Findings: During a review of a facility document titled, Resident Census, dated 7/11/20, it indicated Resident 1 and Resident 2 were roommates. During an observation on 7/14/20, at 10:10 a.m., at the facility's, Red Zone, area where residents with diagnosed COVID-19 infections were confined, the rooms therein were separated from the rest of the facility by a white, non-transparent, plastic barrier. Just outside of this enclosed area was another resident room. During an interview on 7/14/20, at 10:15 a.m., in the Conference Room, Licensed Staff B stated the facility began testing facility staff and residents for COVID-19 infection after a housekeeper was diagnosed as having COVID-19 infection on 7/7/20. Licensed Staff B stated, the facility received the results of the COVID-19 tests on 7/11/2020, at 12 p.m., and three residents, Resident 2, Resident 3, and Resident 4, all tested as having COVID-19 infection. Licensed Staff B stated Resident 1 was placed on isolation precaution because she was a roommate of Resident 2. Licensed Staff B stated the facility had adequate supply of PPE available to staff. During a concurrent observation and interview on 7/14/20, at 1 p.m., CNA A was coming out of a resident room, while still wearing her gown, even though there was a trash bin located just outside the room, and the proper steps of donning and doffing of PPE was posted on this room's door. This room housed a PUI. CNA A removed her face shield and wiped it off with a disinfectant wipe. CNA A then proceeded to the nurses' station to perform hand washing with soap and water at the sink. When CNA A was asked about the training she received regarding the proper donning and doffing (wearing an removing of PPE) when entering an isolation room (isolation rooms assist in separating people who were exposed to a contagious disease and help protect the public by preventing further exposure), she stated she knew she made an error by not removing the gown prior to exiting this resident room. At the hallway, in front of another room, CNA A removed the protective gown and walked all the way to Station 2's shower room to discard the gown. During an interview on 7/14/20, at 2:55 p.m., Licensed Staff B was asked about her expectation of donning and doffing of PPE in an isolation room. Licensed Staff B stated she did in-services on donning and doffing every week. Licensed Staff B stated, and acknowledged, some staff were still not able to appropriately perform the task, and the training's were ongoing. Licensed Staff B stated she expected staff to remove the gown and discard it inside the room, prior to exiting the isolation room.

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