STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056176	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PACIFIC HEIGHTS TRANSITIONAL CARE CENTER	**2707 PINE STREET SAN FRANCISCO, CA 94115**

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 -** Some	**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 its Infection Prevention and Control Program when: 1. Certified Nurse Assistant 2 (CNA 2) did not ensure her facemask cover her nose and mouth. 2. Housekeeper 1 did not wear gloves during the process of cleaning a resident's room. 3. Facility Screener 1 failed to ensure all questions listed on the Visitor Screening TOOL for [MEDICAL CONDITION] (COVID-19 were answered on certain days for the month of July 2020. These deficient practices had a potential result for spread of Coronavirus (COVID-19). Findings: 1. During observations on 7/8/2020, at 10:26 AM, CNA 2's facemask was on, but it hung below her chin. The facemask did not cover CNA 2's nose and mouth as she walked from room [ROOM NUMBER], to the dirty utility room to dispose a bag of garbage, to the nurses' station to wash her hands, and as she went to talk to someone in room [ROOM NUMBER]. During a concurrent review of document titled, Resident Listing Report, dated 7/8/2020, the list indicated room [ROOM NUMBER], Bed A, B and C; and room [ROOM NUMBER], Bed A, B, C and D were occupied by residents. During a concurrent observation and interview on 7/8/2020, at 10:29 AM, CNA 2 stated, I'm Sorry as she adjusted her facemask that hung below her chin on to her face. CNA 2 stated she should have had her facemask on. During a concurrent observation and interview on 7/8/2020, at 10:32 AM, at the nurse's station, CNA 2 had her facemask on, but her nose and nostrils were exposed. CNA 2 stated that her facemask should cover her nose and nostrils. 2. During an observation on 7/9/2020, at 10:56 AM, Housekeeper 1 wet mopped the floor in room [ROOM NUMBER]. The housekeeper did not have gloves on. During a review of document titled, Resident Listing Report, dated 7/9/2020, the list indicated room [ROOM NUMBER] was a three bed room (Bed A, B and C), but only Beds A and C were occupied. During an observation on 7/9/2020, at 11 AM, Housekeeper 1 continued mopping the floor without gloves on. During an observation on 7/9/2020, at 11:03 AM, in the dirty utility room, Housekeeper 1 disposed the dirty water used during mopping without wearing a pair of gloves. During an interview on 7/9/2020, at 11:58 AM, the Environmental Director stated that gloves should be worn while mopping, when done, dirty gloves should be taken off, then hands should be washed. In addition, the Environmental Director stated that gloves should have been worn when the dirty water was disposed. Review of document titled, Infection Prevention and Control: Novel Coronavirus (COVID-19), revised 6/9/2020, indicated, Page 1 of 15, Policy . to minimize exposure to respiratory pathogens . adhere to Standard, Contact and Airborne Precautions . Note: All healthcare personnel will be trained and capable of implementing infections control procedures and adhere to requirements . Procedure . Page 2 of 15 . Facility staff will . follow Standard, Contact, Droplet and/or Airborne Precaution . essential personnel to enter the room with appropriate Personal Protective Equipment (PPE) . Page 5 of 15 . PPE includes: gloves . Facemask . Hand Hygiene . before and after all . contact with infectious material . Page 13 of 15, addendum to Policy: Implementation of Universal Masking Protocol, Effective Date: April 6, 2020 . Facemasks help to provide protection against respiratory droplet spread . AIM . Decrease the spread of infection among residents and healthcare personnel by providing source control . REQUISITES . Proper mask use . including wearing the facemask as directed to cover the mouth and nose . Review of GUIDANCE FOR CLEANING AND DISINFECTING (https://www.cdc.gov/coronavirus/2019-ncov, Accessed 7/15/2020), dated 4/28/2020, indicated, Page 1 of 9 . This guidance is intended for all Americans . requires all of us to move forward together by [MEDICATION NAME] social distancing and other daily habits (Handwashing) to reduce our risk of exposure to [MEDICAL CONDITION] that causes COVID-19 . Page 2 of 9 . Always wear gloves appropriate for the chemicals being used when you are cleaning and disinfecting . Additional personal protective equipment (PPE) may be needed based on setting . include considerations about the safety of custodial staff .These staff should wear appropriate PPE for cleaning and disinfecting . 3. During an observation on 7/8/2020, at 9:15 AM, a visitor was observed entering the facility. Facility Screener 1 (FS1) asked the visitor to complete and write on the COVID-19 screening form. The visitor did not answer the question on the form regarding if the visitor had any symptoms of COVID-19. The visitor left the screening area and made it past the hallway. FS1 did not stop the visitor. During an interview with FS1 on 7/8/2020, at 9:20 AM, and concurrent record review of facility undated document, titled Visitor Screening Tool for [MEDICAL CONDITION] (COVID-19), FS1 stated that she was responsible for screening all visitors who entered the facility. FS1 would ask the visitor to answer the COVID-19 Screening Tool. FS1 stated she did not ask the questions directly but would tell the visitor to answer Yes or No answers on the Screening Tool. Next, FS1 would take the temperature of the visitor. Then, FS1 would tell the visitor the result of the thermometer reading. FS1 would tell the visitor to write the thermometer reading on the Screening Tool. FS1 acknowledged the visitor did not answer the questions on the Screening Tool. FS1 stated she would find the visitor and ask her to complete the form. FS1 stated that she gave the Screening Tool to the Director of Nursing at the end of the day. During a record review of facility document, titled Visitor Screening Tool for [MEDICAL CONDITION] (COVID-19), dated July 2020, and during a concurrent staff interview with Director of Staff Development (DSD), on 7/9/2020, at 11 AM, it was indicated the Screening Tool was not fully completed in 6 opportunities (2 times on 7/2/20, once on 7/3/20, 3 times on 7/7/20). The DSD acknowledged the above findings. The DSD stated the facility did not have a specific policy and procedure as guidelines for completing the Screening Tool.
F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the facility notification of confirmed COVID cases to residents, their representatives and their families, when: 1. For HCP 1 (Housekeeper) who was tested positive for COVID-19, facility did not send notification to residents and their responsible parties for potential exposure within the specified timeframe; 2. For HCP 2 (Cook) who was tested positive for COVID-19, there was no evidence a facility notification was sent out. 3. There was no evidence the facility provided at least a weekly cumulative updates following the subsequent occurrences of a confirmed COVID-19 infections identified on 6/9/2020 and 6/26/2020. These deficient practices had the potential to negatively affect the physical, mental, emotional, and well-being of residents, their representatives and their families and could potentially impact resident's quality of life related to a possible exposure to COVID-19. Definitions: According to the Center for Disease Control and Prevention, Coronavirus (COVID-19) is an illness caused by [MEDICAL CONDITION] that can spread from person to person. [MEDICAL CONDITION] that causes COVID-19 is a new coronavirus that has spread throughout the world. COVID-19 symptoms can range from mild (or no symptoms) to severe illness. COVID-19 is primarily spread from person to person. It can be spread by coming into close contact (about 6 feet or two arm lengths) with a person who has COVID-19, thru respiratory droplets when an infected person coughs, sneezes, or talks and /or by touching a surface or object that has [MEDICAL CONDITION] on it, and then by touching your mouth, nose, or eyes. COVID-19 is caused by a coronavirus called [DIAGNOSES REDACTED]-CoV-2. Coronaviruses are a large family of viruses that are common in people and many different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS (Middle East Respiratory Syndrome (MERS) is [MEDICAL CONDITION] respiratory illness that is new to humans. It was first reported in Saudi Arabia in 2012 and has since spread to several other countries, including the United States. Most people infected with MERS-CoV developed

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 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) severe respiratory illness, including fever, cough, and shortness of breath)-CoV and [DIAGNOSES REDACTED]-CoV, and now with [MEDICAL CONDITION] that causes COVID-19. [DIAGNOSES REDACTED] (Severe acute respiratory syndrome ([DIAGNOSES REDACTED]) is a [MEDICAL CONDITION] respiratory illness caused by a coronavirus called [DIAGNOSES REDACTED]-associated coronavirus ([DIAGNOSES REDACTED]-CoV). [DIAGNOSES REDACTED] was first reported in Asia in February 2003)-CoV-2 virus is a betacoronavirus, like MERS-CoV and [DIAGNOSES REDACTED]-CoV. All three of [MEDICAL CONDITION] have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. Findings: 1. During a group interview, on 7/8/2020 at 1:45 PM, with the Facility Administrator (FA), Regional Infection Control Preventionist, Director of Nursing (DON) and the Regional Resource Person, the FA stated in June, 2020, two staff tested positive for COVID -19, HCP 1 (Housekeeper) and HCP 2 (Cook). The FA stated the HCP 1 was assigned on the second floor, was quarantine (separated and restricted the movement of people who were exposed to a contagious disease to see if they become sick), and had returned to work, but the HCP 2 was still out at this time. Review of the facility's document April -June, 2020 Surveillance Case Log of Health Care Personnel (HCP) with Acute Respiratory Illness and/or Pneumonia, xxx (name of the facility)- HCP Covid Detected indicated, HCP 1 tested positive for COVID-19 and completed 14 day quarntine. During an interview, on 7/8/2020, at 1:50 PM, with the DON, the DON stated HCP 1 did not have any resident's contact, she only mopped the floors of resident's rooms and had confirmed COVID test on 6/9/2020. Record review of the Avellino CoV2 Patient Report dated 6/9/2020, indicated, HCP 1 tested COVID-19 positive for the sample collected on 6/9/2020. During an observation and interview, on 7/9/2020 at 11:50 AM, Resident 1 was in her room, awake, with oxygen via nasal cannula connected to an oxygen concentrator machine, sitting upright in her bed, watching a TV (television) show. When asked if she was told of COVID cases in the facility, Resident 1 stated she did not know, she could not recall, turned her face away, and stated: I am scared (of COVID -19). Review of the Nurses Notes (NN) dated 6/18/20 indicated Resident 1's Responsible Party (RP) was notified on 6/18/20. It read: Tried contacting RP, . to inform them about the possible exposure on the 2nd floor ., electronically (e)-created and dated by the Nurse Manager (NM) on 6/18/20 at 2:42 PM. During an interview, on 7/9/2020, at 11:55 AM, Resident 2 was in her room, awake, flat in bed and stated staff were wearing face masks, wearing gloves and doing hand hygiene. When asked if she was told of COVID cases in the facility, Resident 2 looked surprised and scared, her eyes wide opened and initially did not respond with her head shaking, and stated no case (of COVID-19). Review of the NN dated 6/15/20, indicated Resident 2's RP was notified on 6/15/20. It read: Called RP . husband, made aware resident . being monitored for . Covid-19 d/t (due/to) potential exposure ., e-created and dated by the NM on 6/15/20 at 2:49 PM. Review of the NN dated 6/15/20 indicated Resident 3's RP was notified on 6/15/20 and it read: called RP ., daughter, made aware resident is being monitored . d/t potential exposure. . e-created and signed by the NM on 6/15/20 at 3:01 PM. During a phone interview, on 7/9/2020 at 12:33 PM with the RP 1 for Resident 3, RP 1 stated on 3/10/2020, she had a conference with the staff and at that time the facility put up a protocol, like they made the visitors filled up a paper for symptoms of COVID, told to cover their faces, and hand sanitizers were available on the unit. When asked if the facility sent out notification of COVID-19 cases, RP 1 stated the facility sent out a telephone notice, sometime in April or May, 2020, that someone had came up with COVID. Review of the NN dated 6/16/20 indicated for Resident 4's RP was notified on 6/16/20, it read: called RP . son made aware resident is being monitored . d/t potential exposure ., e-created by the NM on 6/16/20 at 10:01 AM. During an interview, on 7/9/2020 at 12:57 PM, with the DON, the DON stated Resident 4 was on the 3rd floor and there was no notification sent out to residents on the 3rd floor because the HCP 1 was on the 2nd floor, and only residents and their RPs on the second floor were notified. Record review of the NN, Late Entry, dated 6/17/20, indicated Resident 6's RP was notified on 6/17/20. It read: RP, . was contacted and informed . possible exposure on the 2nd floor ., e-created by the NM on 6/18/20 at 2:32 PM. During an interview, on 7/8/2020, at 3:05 PM, with the DON, the DON was asked how residents and their families were notified of confirmed COVID-19 cases. The DON stated, only residents who were exposed were notified (in this case, only residents on the second floor) of possible exposure and for the resident's RPs, it will not be communicated within 24 hours. The DON explained it would be a case to case basis, and if she (DON) did not have enough staff to call the families, the communication would not happened within 24 hours. During a concurrent review of the facility policy and follow-up interview, on 7/8/2020 at 3:30 PM, with the DON, the DON acknowledged facility notifications were sent out late and It's our fault not to do it in a timely manner. 2. Review of the April-June, 2020 Surveillance Case Log of Health Care Personnel (HCP) with Acute Respiratory Illness and/or Pneumonia, xxx (name of the facility)-HCP Covid Detected indicated HCP 2 tested COVID-19 Positive on 6/26/20. During an interview, on 7/8/2020 at 1:51 PM with the DON, the DON stated HCP 2, also worked in another outside facility, had COVID test done by the outside facility and the outside facility communicated to them the confirmed COVID test result done on 6/26/2020. During an interview, on 7/8/2020 at 3:37 PM, with the DON, the DON verified there was no facility notification sent out when HCP 2 had confirmed COVID-19 test on 6/26/2020. When asked why family needed to be notified, the DON stated, they have to know. Everyone have to know and it's in the guidelines, it's their right to know. 3. During an interview, on 7/9/2020 at 10:25 AM, with the FA, the FA stated the facility used the system called Alert Media, an outside company that helped with any facility communications and would communicate with anyone of their own choosing. The FA stated the company would set-up phone messages, set-up e-mails or set-up text messages to communicate with staff, residents, or families. The FA explained the facility would upload the contact list, choose how they communicate, example: text, e- mail. The facility would draft the script and upload the content and sent it out. If no one responded, it would re-try again in 20 minutes. The FA stated Alert Media was started on 4/23/20, it was a contract for 2 years, and was used during the outbreak. All residents, RPs, and person with DPOAs (Durable Power of Attorney) were informed; notices were sent out to informed of the outbreak, discussed the number of people involved and were in contact with the local agencies. During an interview, on 7/9/2020 at 12:33 PM, with RP 1 (for Resident 3), RP 1 stated a telephone notice was sent out, sometime in April, 2020, it was a voice message sent out to the family, that someone had come up with COVID. During an interview, 7/9/2020 at 12:38 PM, with RP 2 (for Resident 5), RP 2 stated the facility notified her that someone came up with COVID, sometime in April, 2020. Review of the Alert Media dated 4/23/20 at 8:47 PM, indicated a notification details of the events related to COVID -19 and the mitigation actions implemented by the facility to reduce the risk of transmission of infections and a contact e-mail address for questions. During a follow-up interview, on 7/9/2020 at 11:13 AM, with the FA and the DON, the FA stated there was no Alert Media sent out following the two cases identified on 6/9/2020 and 6/26/2020. The FA acknowledged there was no cumulative updates sent out, the facility have a system (Media Alert) for notification and could have used it, but, we did not do that. Review of the facility policy titled Infection Prevention and Control: Novel [MEDICAL CONDITION] (COVID-19) with the last revised date of 6/9/20 indicated: IV. Communication and Reporting: The facility will review the communication procedures for COVID-19 (initial, . and upon suspected or confirmed outbreak) through multiple means (i.e. . and recorded messages for receiving calls) to inform individuals and non- essential health care personnel .Facility will notify residents, residents' representatives, and families of residents of confirmed or suspected COVID-19 cases in the facility among residents and staff. Notification by 5 PM the next calendar day following occurrence of either: a. A single confirmed infection of COVID-19 OR b. Three or more residents or staff with new-onset respiratory symptoms occurring within 72 hours of each other . There was no mention in the policy to include any cumulative updates for residents, their representatives, and families of at least a weekly updates following the subsequent occurrence each time a confirmed infection of COVID-19 was identified.