STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555115	A. BUILDING _____ B. WING _____	07/29/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OAKHURST HEALTHCARE CENTER	40131 HIGHWAY 49 OAKHURST, CA 93644

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 and maintain a safe environment with an effective infection prevention and control program for the prevention of [MEDICAL CONDITION] (COVID-19- a contagious serious respiratory infection transmitted from person to person) and [MEDICAL CONDITION] (C. diff -bacterial infection that causes life threatening diarrhea) transmission for 5 of 5 sampled Residents (Residents 7, 8, 9, 13 and 14) when: 1. Signage for the type of transmission based precaution (an alert system to caution staff and visitor to adhere to practices to prevent spread of the disease) was not posted outside of a COVID-19 area designated for Persons Under Investigation (PUI - residents identified as at risk of exposure to Covid) room for Residents 8, 9 and 13. 2. Resident 7 was isolated for [DIAGNOSES REDACTED] infection and the room had no signage posted outside the room to alert staff and visitors of isolation precautions to follow. 3. Staff did not equip Resident 7's room with dedicated equipment, such as blood pressure cuff and thermometer as per facility policy and procedure and infection control standards to reduce the spread of [DIAGNOSES REDACTED]. CNA 3 took Resident 8 and 13's blood pressure and temperature with the same equipment used in the [DIAGNOSES REDACTED] isolation room without disinfecting the equipment with an agent that would kill C.diff bacteria. 4. Staff did not follow infection control standards to isolate[DIAGNOSES REDACTED] once Resident 7 was suspected of having C.diff. Resident 7 shared rooms with Resident 14, Resident 7 had symptoms of diarrhea and was suspected of having [DIAGNOSES REDACTED] on 7/23/2020 and was not placed on isolation precautions until 7/28/2020. 5. Staff did not follow Infection Control standards of practice when Resident 7 had a lab order on 7/23/2020 for [MEDICAL CONDITION] (C. diff -bacterial infection that causes life threatening diarrhea) stool culture which was not collected until 7/27/2020. These failures had the potential to increase the risk of transmission of COVID-19 and [DIAGNOSES REDACTED] infection to all Residents and staff of the facility. Findings: 1. During a concurrent tour of the facility and interview on 7/29/20 at 8:25 a.m., with the Director of Nursing (DON), the DON stated rooms 16 through 23 are the area designated for the people under investigation (PUI). During the tour, there were residents in rooms 19, 21 and 23. The DON stated they had come back from the hospital and are being monitored for fourteen days for signs and symptoms of COVID-19. The DON stated Resident in room [ROOM NUMBER] is being isolated for [MEDICAL CONDITION]. During the tour there were no signs posted outside Res 19, 21 and 23 wall or door indicating the type of transmission based precautions. During an interview on 7/29/20 at 9:10 a.m., with the Infection Preventionist/Director of Staff Development (IP/DSD), the IP/DSD stated the signs indicating the type of transmission based precaution should have been placed outside the residents rooms. The IP/DSD stated the licensed nurse is responsible to make sure the appropriate signage is posted. 2. During an observation on 7/29/2020, at 9:35 a.m., in the north hallway, Resident 7's room did not have an isolation precaution sign posted outside of the room to indicate the type of isolation precautions staff and visitors would need to take prior to entering the room. During a concurrent observation and interview on 7/29/2020, at 10:16 p.m., with Licensed Vocational Nurse (LVN) 1, in the north hallway, LVN 1 stated Resident 7 was on isolation for [DIAGNOSES REDACTED] and validated that there was no type of isolation precaution sign posted on Resident 7's door. LVN 1 stated a sign indicating the type of isolation precaution and type of PPE required prior to entering the room should have been posted on the door and it was not. LVN 1 stated the purpose of posting an isolation precaution sign was to inform staff and visitors on precautions to take to prevent the spread of the highly contagious [DIAGNOSES REDACTED] infection. During a concurrent interview and record review on 7/29/2020, at 2:40 p.m. with Registered Nurse (RN) 1, Resident 7's (company name) lab results dated 7/28/2020 were reviewed. The laboratory results indicated, .C. DIFFICILE .RESULT POSITIVE . RN 1 stated Resident 7 was placed on isolation precautions on 7/28/2020 for [DIAGNOSES REDACTED]. During a concurrent interview and record review on, 7/29/2020, at 4:26 p.m., with IP/DSD, the facility policy and procedure titled Resident Isolation - Initiating Transmission-Based Precautions dated 4/22/2016 was reviewed. The policy indicated, When transmission-based precautions are implemented, the Infection Control Coordinator (or designee): .Posts the appropriate notice on the room entrance door and on the front of the resident's chart so that all personnel are aware of precautions, or aware that they must first see a nurse to obtain additional information about the situation before entering the room . IP/DSD stated to prevent the spread of [DIAGNOSES REDACTED] infection a sign should have been posted but was not. Review of professional reference retrieved on 7/31/2020, from https://apic.org/Resource_/TinyMceFileManager/Practice_Guidance/cdiff/C.Diff_Digital_Toolkit_GNYHA.pdf titled, REDUCING [DIAGNOSES REDACTED]ICILE INFECTIONS TOOLKIT undated, indicated, .One element in the [DIAGNOSES REDACTED]icile collaborative is to initiate immediate contact precautions for patients with [DIAGNOSES REDACTED]icile, part of which involves placing signs on the door of the infected patient's room to notify support staff, clinicians, patients, and visitors of the need to take special precautions before entering . 3. During an observation on 7/29/2020, at 9:35 a.m., in the north hallway, Resident 7's room had a plastic three-compartment drawer. A germicidal (brand name} agent wipes that would not kill C.diff was placed on top of the drawer. During a concurrent interview and record review on, 7/29/2020, at 10:16 a.m., with LVN 1, the label for (brand name) disinfectant germicidal wipes located in front of Resident 7's room was reviewed. LVN 1 stated the label had a list of microorganisms that it killed but the wipes did not kill [DIAGNOSES REDACTED] bacteria. LVN 1 stated Resident 7 did not have dedicated equipment in her room. LVN 1 stated wipes that effectively kill [DIAGNOSES REDACTED] should be used on equipment to prevent the spread of infection. During a concurrent interview and record review on, 7/29/2020, at 1:50 p.m., with Certified Nursing Assistant (CNA) 3, the label for (brand name) disinfectant germicidal wipes was reviewed. CNA 3 validated she had used the disinfectant (brand name) with the white cap to disinfect the glucometer and thermometer after use on Resident 7. CNA 3 stated after taking Resident 7's blood pressure and temperature she used the same equipment on Resident 8 and 13. CNA 3 stated using a disinfectant that does not kill [DIAGNOSES REDACTED] could spread infection. During a concurrent interview and record review on, 7/29/2020, at 4:26 p.m., with IP/DSD, the facility policy and procedure titled Resident Isolation - Categories of Transmission-Based Precautions dated 1/1/2012 was reviewed. The policy indicated, .Contact precautions .Resident care equipment .When possible, the use of non-critical resident-care equipment items . are dedicated to a single resident (or cohort of residents) to avoid sharing between residents . IP/DSD, IP/DSD stated Resident 7 should have had dedicated equipment to prevent cross contamination but did not. Review of professional reference retrieved on 7/31/2020, from https://www.cdc.gov/hai/prevent/cdi-prevention-strategies.html titled, Strategies to Prevent Clostridioides difficile Infection (CDI) in Acute Care Facilities dated 8/7/19, indicated, . Use dedicated patient-care equipment (e.g., blood pressure cuffs, stethoscopes) . During a concurrent interview and record review on, 7/29/2020, at 4:30 p.m., with IP/DSD, the facility policy and procedure titled [MEDICAL CONDITION] dated 7/14/2017 was reviewed. The policy indicated, .The facility will care for persons with [MEDICAL CONDITION] .and act to prevent transmission of [MEDICAL CONDITION] to others .Due to the spore forming nature of [DIAGNOSES REDACTED]icile and its ability to survive on dry surfaces for many months,

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 -** Some	(continued... from page 1) the disinfectant recommended for cleaning the environment is a bleach solution . IP/DSD stated central supply had not placed the appropriate wipes to kill [DIAGNOSES REDACTED]. IP/DSD stated a disinfectant which kills [DIAGNOSES REDACTED] should be used to prevent the spread of infection but was not. Review of professional reference retrieved on 7/31/2020, from https://www.cdc.gov/hai/prevent/cdi-prevention-strategies.html titled, Strategies to Prevent Clostridioides difficile Infection in Acute Care Facilities dated 8/7/19, indicated, . Perform daily cleaning of CDI patient rooms using a [DIAGNOSES REDACTED]icile sporicidal agent (EPA List K agent) .Clean and disinfect all shared equipment prior to use with another patient . Review of professional reference retrieved on 8/3/2020, from https://www.mayoclinic.org/diseases-conditions/[MEDICAL CONDITION]/symptoms-causes/syc- 691 titled, [DIAGNOSES REDACTED]icile infection dated 1/4/2020, indicated, . In hospitals and nursing homes, [DIAGNOSES REDACTED]icile spreads mainly on hands from person to person, but also on cart handles, bedrails, bedside tables, toilets, sinks, stethoscopes, thermometers - and even telephones and remote controls . In any health care setting, all surfaces should be carefully disinfected with a product that contains chlorine bleach. [DIAGNOSES REDACTED]icile spores can survive exposure to routine cleaning products that don't contain bleach. 4. During a concurrent interview and record review on 7/29/2020, at 2:40 p.m. with RN 1, Resident 7's NURSE'S NOTES DATED 7/23/2020 was reviewed. The NURSE'S NOTES indicated, .N/O (new order) to collect stool sample test for [MEDICAL CONDITION] .Resident has been having loose, mucousy / slimey stools, that are foul smelling . RN 1 stated she was assigned to Resident 7 on 7/23/2020 when Resident 7 developed symptoms such as three loose stools stomach pain and lack of appetite. RN 1 she had suspected Resident 7 for having [DIAGNOSES REDACTED] and informed the Primary Physician (PM) whom was at the facility. RN 1 stated PM wrote an order for [REDACTED]. RN 1 stated it was her responsibility to place Resident 7 on isolation to prevent the spread of infection. During an interview on 7/29/20, at 4:26 p.m., with IP/DSD, IP/DSD stated Resident 7 and Resident 14 shared rooms. IP/DSD stated Resident 7 could have exposed Resident 14 to infection since she was not placed on isolation precautions until 7/28/2020 During a review of Resident 7's order sheet, dated 7/23/2020, the order sheet indicated, Resident 7 had an order for [REDACTED]. The policy indicated, .Contact precautions are implemented for residents known or suspected to be infected or colonized with microorganisms that are transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment . IP/DSD stated it was the facility's policy to place Resident 7 on contact isolation when suspected of having [DIAGNOSES REDACTED] to prevent the spread of infection. Review of professional reference retrieved on 7/31/2020, from https://www.cdc.gov/cdiff/clinicians/faq.html titled, FAQs for Clinicians about [DIAGNOSES REDACTED] dated 3/27/2020, indicated, . What are the steps to prevent spread . Isolate patients with [DIAGNOSES REDACTED] immediately, even if you only suspect CDI . 5. During a concurrent observation and interview on 7/29/2020, at 10:16 p.m., with Licensed Vocational Nurse (LVN) 1, in the north hallway near Resident 7's room, LVN 1 stated Resident 7 was on isolation for [DIAGNOSES REDACTED]. Resident 7 was observed in his room. During a concurrent interview and record review on 7/29/2020, at 2:40 p.m. with RN 1, Resident 7's NURSE'S NOTES DATED 7/23/2020 was reviewed. The NURSE'S NOTES indicated, .N/O (new order) to collect stool sample test for [MEDICAL CONDITION] .Resident has been having loose, mucousy / slimey stools, that are foul smelling . RN 1 stated she was assigned to Resident 7 on 7/23/2020 when Resident 7 developed symptoms such as three loose stools stomach pain and lack of appetite. RN 1 stated, she had suspected Resident 7 for having [DIAGNOSES REDACTED] and informed the Primary Physician (PM) whom was at the facility. RN 1 stated PM wrote an order for [REDACTED]. RN 1 stated it was her responsibility to ensure the lab was drawn sooner to prevent the risk of infection and contamination. RN 1 stated she should have followed through with the order since she was the one to obtained the order on 7/23/2020. During a concurrent interview and record review on 7/29/2020, at 2:40 p.m. with Registered Nurse (RN) 1, Resident 7's (company name) lab results dated 7/28/2020 was reviewed. The lab indicated, .C. DIFFICILE .RESULT POSITIVE . RN 1 stated Resident 7 was placed on isolation precautions on 7/28/2020. During an interview on 7/29/2020, at 3:16 p.m., with Director of Nursing (DON), DON stated, Licensed Nurse's should have collected the lab as soon as the resident had a bowel movement. DON stated the lab collection took longer than what she would expect. DON stated the lab should have been taken when the lab order was obtained. During an interview on 7/30/2020, at 3:09 p.m., with PM, PM stated, it was not standard of care to delay the collection of the stool culture. PM stated, his order should have been carried out immediately. During a review of the facility's policy and procedure titled, Physician Orders, dated 1/1/2012, the policy indicated, .Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order . Review of professional reference retrieved on 8/3/2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC 05/ titled, Easily Modified Factors Contribute to Delays in [DIAGNOSES REDACTED].Delays in testing contributed to delays in initiation of treatment for [REDACTED]. An intervention that addressed several easily modified factors contributing to delays resulted in a significant decrease in the time required to complete CDI testing. These findings suggest that health care facilities may benefit from a review of their processes for CDI testing to identify and address modifiable factors that contribute to delays in [DIAGNOSES REDACTED].