STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055658	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWILIGHT HAVEN	**1717 S. WINERY AVENUE FRESNO, CA 93727**

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, interview and record review the facility failed to maintain their infection prevention and control program designed to provide a safe and sanitary environment to help prevent the spread and transmission of communicable disease and infections when, 1. Staff member 2, a certified nursing assistant (CNA) failed to disinfect re-usable eye protection when removed and placed the contaminated equipment in the clean storage area. 2. Two of four sampled residents (Residents 2 and 3) identified as COVID-19 positive or at risk for developing COVID-19, were not consistently monitored for worsening or developing signs and symptoms of COVID-19 during an outbreak of COVID-19 in the facility, and 3. An unsecured container half full of used sharps (needles, syringes, or other sharp medical devices) was stored on a shelf without a lid. These failures had the potential for staff to contaminate and spread the [DIAGNOSES REDACTED]-CoV-2 virus which causes COVID-19 illness to other staff and residents; Delay early recognition of and response to COVID-19 illness which can rapidly develop or worsen, and potentially spread the infection if a resident is not already isolated. An unsecured sharps container without a lid poses the risk of tipping over and potentially injuring and infecting staff with blood borne pathogens through a sharps injury. Findings: 1. Disinfection of reusable face shield: Observed CNA2 on 08/03/2020 at 3:15 PM enter the COVID-19 unit at the facility. Centers for Disease Control (CDC) signage titled Sequence for Putting On Personal Protective Equipment and How to Safely Remove Personal Protective Equipment were posted just inside the COVID-19 unit doorway. CNA2 was wearing a respirator and face shield upon entering the unit. CNA2 removed the face shield and placed it into a storage device pocket hanging by the door, and then performed hand hygiene with an alcohol based hand rub. CNA2 did not disinfect the face shield upon removal and placement into the storage pocket. She then donned (put on) an isolation gown and performed hand hygiene. CNA2 removed the face shield from the storage pocket, donned it and a pair of gloves, and then entered the room of a resident with COVID-19. Observed CNA2 doff the personal protective equipment (PPE) a few minutes later. CNA2 removed her gloves and placed them in a trash bin, then removed her gown being careful to not touch the outside of the gown and placed it in the trash bin. CNA2 then performed hand hygiene. Following this step, she removed the face shield and placed it into the storage pocket and again performed hand hygiene. CNA2 did not disinfect the face shield upon removal, or before placing in the storage pocket. Interviewed CNA2 outside of the COVID-19 unit immediately after exiting the unit. CNA2 stated she had worked at the facility for three days, and was hired through a registry agency. CNA2 described the storage rack for the face shields as having individual pockets assigned to staff members who worked on the COVID-19 to store their clean face shields when not in use. When asked about disinfection practices for the reusable face shield, she stated typically I clean it when I'm leaving the area. When asked to describe what the facility had taught her to do regarding disinfection of reusable face shields, she was not able to recall. When asked if storing a face shield in the storage pocket without disinfecting it could contaminate that clean storage, she replied I didn't think of that and confirmed it could contaminate the storage device. Record review of CDC sign titled How to Safely Remove Personal Protective Equipment on 08/03/2020 revealed directions for removing face shield. It read in part, If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container. The facility's Infection Preventionist (IP) was interviewed on 08/03/2020 at 4:45 PM about the disinfection practices of reusable face shields. The IP stated staff should disinfected after doffing, they should wipe it with a germicidal and let dry for two minutes. The IP clarified this should be done whenever they take it off. Facility's COVID-19 Mitigation Plan with revision date of 08/02/2020 was reviewed on 08/04/2020. The section titled Personal Protective Equipment read Signage will be posted outside resident rooms when they are either on contact isolation (PUI) or airborne precautions (COVID-19 positive residents). The signage will be on the door at eye level. They will include the type of precaution needed, the PPE needed, and donning and doffing instructions. It further read, Staff will doff PPE in the room except for the mask and face shield, we are [MEDICATION NAME] extended use on those. The plan did not include a detailed procedure for when or how to disinfect and reuse the face shields. Facility Policy titled Resident Isolation - Use of Equipment and Supplies numbered IC-27 read Appropriate equipment and supplies are used to maintain sanitary conditions while isolation precautions are in effect. Procedure step IV read Equipment is cleaned and sanitized before it is returned to Central Supply or to designated storage areas. Review of the CDC's Strategies for Optimizing the Supply of Eye Protection dated 07/15/2020 available on their web site at https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html read, If a disposable face shield is reprocessed, it should be . reprocessed whenever it is visibly soiled or removed. 2. Monitoring: Interviewed Licensed Nurse (LN) 3 on 08/03/2020 at 4:05 PM regarding the monitoring of residents for signs and symptoms of COVID-19. LN3 stated that staff monitored all residents for any new symptoms of developing COVID-19 or worsening sign and symptoms of ill residents, especially cough, shortness of breath, temperature and sore throat. She stated the monitoring was documented in the Medication Administration Record [REDACTED]. She also stated that new or worsening symptoms would be reported to the Director of Nursing (DON) and administration to initiate any next steps. Resident 2's electronic health record (EHR) was reviewed on 08/04/2020. The census tab of the record revealed Resident 2 was admitted to the facility on [DATE]. admitting [DIAGNOSES REDACTED]. The principle [DIAGNOSES REDACTED]. A review of the July MAR indicated [REDACTED]= symptoms present (;) N= no symptoms present. If symptoms are present notify MD and DON and complete a progress note. Specify the symptom in your progress note. Four shifts for the month of July were blank, July 9th night shift, July 14th day shift, July 27th day shift, and July 30th evening shift. Progress notes and vital sign entries were reviewed, no nursing notes or vital signs were located in the record for two of the dates, 07/09/2020 evening shift, or 07/14/2020 day shift. Interviewed the DON on 08/05/2020 at 10:50 AM regarding monitoring of residents. The DON stated they have the licensed nurses monitor residents every shift for both usual and unusual signs and symptoms of COVID-19. We have it in the MAR . when the nurse identifies something unusual, they will text me or call me. During a concurrent record review, the DON confirmed there was no monitoring of Resident 2 for two shifts in July (7/9 evening shift, and 7/14 day shift). The DON verified by checking written vital sign sheets used by the staff during each shift, as well as reviewing Resident 2's medical record. Resident 3's EHR was reviewed on 08/04/2020. The census tab of the record revealed Resident 3 had resided on the East Hall of the facility from 01/01/2020 to 07/31/2020 when Resident 3 moved to a room on the West Hall. The July MAR indicated [REDACTED]. Five shifts for the month of July were blank, July 9th, 14th, and 17th on the day shift, and July 21st, and 26th on the evening shift. Progress notes and vital sign entries were reviewed, no nursing notes or vital signs were located in the record for 3 of those July shifts: the 14th day shift, the 17th day shift, and the 21st evening shift. During the concurrent interview and record review with the DON on 08/05/2020 at 10:50 AM, the DON confirmed there was no monitoring for the July 14th day shift, 17th day shift, or 21st evening shift. He stated It's not there after checking written vital sign sheets used by the staff during each shift. Facility's COVID-19 Mitigation Plan with revision date of 08/02/2020 was reviewed on 08/04/2020. Under the heading Resident Screening and Testing it read, During each shift residents will have their vitals taken and be screened for fever and symptoms of COVID-19 including taking their (oxygen saturations). 3. Sharps Safety: Observed a sharps container in the IP's office on 08/05/2020 at 11:05. A sharps container is a puncture

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 -** Few	(continued... from page 1) resistant container used in health care settings to dispose of used sharp instruments such as needles, scalps, or other sharp items. They have lids designed to prevent items from accidental or intentional removal. The observed container was a red plastic rectangular container approximately 10 inches wide, 10 inches tall, and 5 inches wide. The top of the container was open and was approximately 10 by 5 inches in size. There was not a lid on the container. The container was translucent and 1/2 full of used sharps (needles). It was sitting on a shelf above a desk in the office. Interviewed the IP on 08/05/2020 at 11:17 AM about the open, half-filled container of used sharps. The IP acknowledged that the container did not have a lid a posed a risk of sharps injuries and infection. When asked if it was an appropriate container or could tip over, and spill dirty sharps onto a person, she stated let me fix that right now. She immediately removed the container, fitted a lid on it and stated she would secure it. Facility policy titled Stand Precautions read Standard Precautions presume that blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Under section H. Safe Needle Handling it read, Care is taken to prevent injuries when using needles, scalpels, and other sharp instruments or devices; . and when disposing of used needles. It further read, Disposable syringes and needles, scalpel blades, and other sharp items are placed in appropriate puncture-resistant containers located as close as practicable to the area in which the items were used.