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 _____	09/28/2020

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 -** 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 implement and maintain a safe environment with an effective infection prevention and control program for the prevention of [MEDICAL CONDITION] ((COVID-19)- [DIAGNOSES REDACTED]-CoV-2 -a contagious serious respiratory infection transmitted from person to person) when: 1. COVID-19 positive and Persons Under Investigation (PUI -persons exposed to someone infected with COVID-19 or who is experiencing symptoms for COVID-19 but not yet laboratory positive for COVID-19) resident room doors for four sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4) in the COVID-19 positive and PUI unit remained open and not closed in accordance to the Centers for Disease Control (CDC) recommendations. 2. The plastic partition separating the section of the facility between the COVID-19 positive designated area and the non-COVID area was not decontaminated and cleaned before and after each staff entered or exited the COVID-19 unit. The plastic partition was equipped with a red-colored zipper which was used to enter and exit the COVID-19 positive section. 3. One of three sampled staff License Vocational Nurse (LVN) 1 notified the facility she was experiencing COVID-19 symptoms on 9/15/20 and LVN 1 was allowed to report to work from 9/16/20 through 9/19/20 experiencing COVID-19 symptoms. These practices potentially placed the residents and staff at risk for the spread and transmission of COVID-19, complications and death from the COVID -19 virus. Findings: 1. During a concurrent observation and interview on 9/24/20, at 2:06 p.m., with Certified Nursing Assistant (CNA) 5, in the confirmed COVID-19 and PUI designated area, Resident 1, Resident 2, Resident 3, and Resident 4's bedroom doors were left open. CNA 5 validated the room doors were open and stated that the bedroom doors remained open to monitor residents because the four residents were considered fall risk. During a concurrent interview and record review on 9/25/20, at 10:56 a.m., with Director of Nursing (DON) and Infection Preventionist (IP), the DON stated the facility used CDC as guideline for following infection control practices. IP stated the bedroom doors remained open in the confirmed COVID-19 and PUI designated area since the Residents were fall risk. The DON and IP reviewed the CDC COVID-19 and PUI room door guidance titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 7/15/20, which indicated, .place patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection in a single-person room with the door closed . The IP stated the facility did not follow the CDC guidance when the CDC's recommendation clearly indicated to keep confirmed COVID-19 and PUI designated area resident room doors closed. During a professional reference review retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html dated 7/15/20, titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic indicated, .2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection . place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection .with the door closed. 2. During an observation on 9/24/20, at 9:07 a.m., in the facility hallway, a plastic partition separating the COVID-19 designated area from the rest of the facility was observed. The plastic partition had a red zipper going down the middle for access into and out of the COVID-19 positive designated area. During an interview on 9/24/20, at 9:30 a.m., with CNA 1, CNA 1 stated when working in the COVID-19 positive designated area she would enter through the partition which required her to open and close the red zipper for access into the COVID-19 designated area. CNA 1 stated she did not know who was responsible for the decontamination and cleaning of the plastic partition since it was a highly touched surface by the staff working in the COVID-19 positive area. During an interview on 9/24/20, at 10:00 a.m., with LVN 3, LVN 3 stated when working in the COVID-19 designated area she would clock into work and proceed to the COVID-19 positive designated area through the plastic partition. LVN 3 stated all staff who entered the COVID-19 positive designated area use the plastic patrician to enter the COVID-19 unit. During an observation on 9/24/20, at 2:13 p.m., in the COVID-19 designated area, LVN 2 walked up to the COVID-19 positive unit plastic patrician and without performing hand hygiene she unzipped the red zipper and entered the COVID-19 designated area through the red zipper attached to the plastic partition. LVN 2 closed the zipper and proceeded to the COVID -19 positive unit break room. During an interview on 9/24/20, at 2:24 p.m., with LVN 2, LVN 2 stated the zipper attached to the partition was a frequently touched surface. LVN 2 stated all staff working in the COVID-19 designated area entered through the partition at the start of their shift. LVN 2 stated she did not know who was responsible for the decontamination and cleaning of the plastic patrician. During a concurrent interview and record review on 9/25/20, at 10:23 a.m., with Housekeeping and Laundry Supervisor (HLS), the facility documented titled Housekeeping Rooms Completed (HRC) undated was reviewed. The HRC included boxes where housekeeping staff placed their initials indicating the halls, linen carts, closet and restrooms had been cleaned for the day. HLS stated the HRC was a check off list for areas cleaned by housekeeping. HLS stated disinfection of the partition was not part of the HRC document and had no tracking system to ensure the disinfection of the partition was performed. HLS stated the partition was a highly touched and potentially infectious area and should have been disinfected. HLS stated it was housekeeping responsibility to disinfect the partition. HLS stated the partition should be part of the cleaning log to ensure it gets disinfected and it was not. During a concurrent interview and record review on 9/25/20, at 10:51 a.m., with the DON, the facility policy and procedure titled, COVID-19 Policy & Procedure dated 3/24/20 was reviewed. The policy indicated, .Routine disinfecting procedures with cleaners and water to pre-clean surfaces prior to disinfecting will be done at a frequency adequate to keep high-traffic and high-touch areas clean .An EPA (Environmental Protection Agency)-registered, hospital-grade disinfectant will be routinely applied to these high contact areas DON stated the facility policy was to disinfect highly touched surfaces. DON stated the partition was a highly touched surface, staff working COVID-19 designated area were instructed to enter the unit through the partition. DON stated it was housekeeping's responsibility to disinfect and log when disinfecting daily and that was not done. 3. During an interview on 9/24/20, at 10:56 a.m., with the IP, she stated LVN 1 called the facility on 9/15/20 and informed them that she was unable to work because she had symptoms of fever and fatigue. The IP stated LVN 1 was allowed to return to work the following day and worked 9/16/20-9/19/20. The IP stated LVN 1 was tested for COVID-19 on 9/16/20 and LVN 1's COVID -19 test results came back positive on 9/20/20. During a telephone interview on 9/24/20, at 1:26 p.m., with LVN 1, LVN 1 stated she worked night shift in the COVID-19 unit. LVN 1 stated she started feeling symptoms of fatigue, feeling tired, and had a fever of 100.4 on 9/14/20. LVN 1 stated she called the facility on 9/15/20 and notified the DON and IP that she was unable to work because of her symptoms. LVN 1 stated she was scheduled to work on the 9/16/20 and was not told to stay home. LVN 1 stated she worked 9/16/20 through 9/19/20 in the COVID-19 unit with symptoms of feeling tired and fatigue. LVN 1 stated she did not think she had COVID-19 and because she called and spoke with the DON and IP and they did not ask her to stay home after she informed them of her symptoms. LVN 1 stated she did not report her symptoms to the screener during the screening process and she should have. LVN 1 stated she went through the weekly facility testing and tested positive for COVID-19 on 9/20/20. LVN 1 stated she should have self-quarantine when her symptoms began on 9/14/20 and she did not do that. LVN 1 stated she could have potentially spread [MEDICAL CONDITION] while working having COVID -19 symptoms and placed residents and other staff members at risk. LVN 1 stated she thought her symptoms of feeling tired and fatigue were from working

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 -** Many	(continued... from page 1) nights and being exposed to the smoke from the fires in the area. LVN 1 stated she aware that symptoms for COVID-19 included fever, fatigue, nausea and vomiting. LVN 1 stated she stayed home and informed the facility of her symptoms on 9/15/20 and was not asked to self-quarantine and reported to work while having symptoms. During an interview on 9/25/20, at 11:35 p.m., with the DON and the IP, the DON stated on 9/15/20 LVN 1 had called the facility to inform them that she was reporting symptoms such as feeling tired and a temperature of 102. The IP stated LVN 1 sent her a text on her cell phone and reported symptoms of nausea, runny nose, headache, body aches, and fever on 9/15/20. The IP stated she did not call LVN 1 after the text she received from her on 9/15/20 and she should have. The DON stated LVN 1 had symptoms of COVID-19 and should not have been told not to come in to work. During a concurrent interview with the DON, and record review on 9/25/20, at 11:50 a.m., the facility document titled, Employee Screening (ES) dated 5/5/20 was reviewed. The ES indicated, .History of any of the following: fever, cough, shortness of breath or sore throat within the last 14 days. DON/Designee to review alternate diagnosis. Return to work should be based on recommendations from MD (Medical Doctor) based on alternate [DIAGNOSES REDACTED]. The DON stated the facility did not have a designated employee to follow up with staff when staff called the facility reporting COVID-19 symptoms and review for alternative diagnosis. During a concurrent interview with the DON, and record review on 9/25/20, at 2:08 p.m., the facility policy and procedure titled, Respiratory Virus (COVID-19, Influenza, RSV etc.) Prevention and Control dated 1/2020, indicated, .The Infection Preventionist and/or designee will monitor and manage ill healthcare personnel. Staff who develop fever and respiratory symptoms will be screened and monitored, if indicated, based on the most current CDC guidelines. Interventions may include: Instructed no to report to work, or if at work, stop resident-care activities . The DON stated staff with symptoms of COVID-19 should be tested and sent home for 14 days and that did not occur with LVN 1. The IP stated LVN 1 worked with 20 residents in the COVID-19 positive unit on the week she had COVID symptoms. The IP stated 19 out of the 20 residents that were exposed to LVN 1 had tested positive for COVID-19 before LVN 1 had experienced COVID-19 symptoms. The IP stated Resident 20 out of the 19th had tested positive on 8/12/20 and had not been retested , until all facility residents were tested on [DATE] and 9/22/20 per the facility response testing. The IP stated Resident 20's COVID -19 test results should be arriving to the facility by 9/26/20. During a concurrent interview with the DON, and record review on 9/25/20, at 3:02 p.m., the professional reference titled, Center for Clinical Standards and Quality/Survey & Certification Group Ref: QSO-20-38-NH dated 8/26/20 indicated, .Staff with symptoms or signs of COVID-19 must be tested and are expected to be restricted from the facility pending the results of COVID-19 testing . The DON stated she should have instructed LVN 1 to stay home and get COVID-19 tested and she did not do that. During a concurrent telephone interview with the DON and record review on 9/28/20, at 12:21 p.m., the DON reviewed Resident 20's (exposure from LVN 1) COVID -19 test results and stated the results were negative.