STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056177	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DOUBLE TREE POST ACUTE CARE CENTER	**7400 24TH STREET SACRAMENTO, CA 95822**

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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to include the type of isolation precautions needed and assessment of vital signs in quarantined residents' (Resident 5, Resident 6, Resident 8, Resident 9, and Resident 10) care plans. This failure decreased the potential for nursing staff to limit spread of COVID-19 and provide immediate care to residents at high risk of an infectious [MEDICAL CONDITION] disease. Findings: A review of Resident 5's clinical record indicated admission to the facility in 2019 and [DIAGNOSES REDACTED]. A review of Resident 6's clinical record indicated admission to the facility in 2018 and [DIAGNOSES REDACTED]. A review of Resident 8's clinical record indicated admission to the facility in 2019 and [DIAGNOSES REDACTED]. A review of Resident 9's clinical record indicated admission to the facility in 2010 and [DIAGNOSES REDACTED]. A review of Resident 10's clinical record indicated admission to the facility in 2020 and [DIAGNOSES REDACTED]. A review of Resident 5, Resident 6, Resident 8, Resident 9, and Resident 10's care plans regarding risk of infection related to exposure to COVID-19 indicated no interventions regarding necessary isolation precautions nor the frequency vital signs needed to be assessed. In an interview on 8/4/20 at 1:43 p.m., the Infection Preventionist (IP) stated isolation precautions and monitoring of vital signs twice per shift should be care planned. A review of the facility's policy and procedure titled Care Plans, Comprehensive Person-Centered, revised 12/16, indicated, The care planning process will .Include an assessment of the resident's .needs .The comprehensive person-centered care plan will .Describe the services that are to be furnished . A review of the facility's policy and procedure titled Care Plans - Baseline, revised 12/16, indicated, Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.
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 ensure proper infection control safety when the facility did not: 1. Post transmission precaution signs immediately outside of resident rooms; 2. Have necessary personal protective equipment (PPE) immediately available outside of resident rooms; 3. Correctly don and doff PPE; 4. Minimize the spread of infectious disease when nursing staff refilled a quarantined resident's cup with water; 5. Sanitize their hands prior to entering and exiting resident rooms; and 6. Position soiled gown bins as near as possible to the exit inside of the resident room to make it easy for staff to place used gown in bin after removal. These failures increased the potential for the spread of communicable disease and infection among residents. Findings: 1. A review of Resident 6's clinical record indicated admission to the facility in 2018 and [DIAGNOSES REDACTED]. A care plan initiated on 7/20/20 indicated Resident 6 was at risk for infection due to exposure to COVID-19 (an infectious disease which causes respiratory tract illness). A review of Resident 8's clinical record indicated admission to the facility in 2019 and [DIAGNOSES REDACTED]. A care plan initiated on 7/11/20 indicated Resident 8 was at risk for infection due to exposure of COVID-19. A review of Resident 7's clinical record indicated admission to the facility in 2020 and [DIAGNOSES REDACTED]. A review of Resident 11's clinical record indicated admission to the facility in 2020 and [DIAGNOSES REDACTED]. A review of the facility's Standard Operating Procedure (SOP) titled Emergency Preparedness Plan COVID-19, dated 3/18/20, indicated, Contact and droplet precautions are implemented during care of residents with suspected COVID-19 . In an observation and concurrent interview on 7/27/20 at 12:20 p.m., the Infection Preventionist (IP) verified the sign posted on Resident 6's door did not indicate the type of transmission-based precaution to be practiced by staff when providing care. In an observation and concurrent interview on 7/27/20 at 12:29 p.m., the Director of Nurses (DON) verified the only sign posted on Resident 8's door did not indicate the type of isolation precaution to be practiced by staff when providing care. In an observation and concurrent interview on 7/27/20 at 12:44 p.m., the Administer in Training (AIT) verified the sign posted on Resident 7's door did not specify the transmission precaution to be practiced by staff when providing care. In an observation and concurrent interview on 7/27/20 at 4:54 p.m., the Certified Nurse Assistant 2 (CNA 2) verified the sign posted on Resident 11's door did not specify the type of isolation to be practiced by staff when providing care. A review of the facility's policy and procedure titled Isolation- Categories of Transmission-Based Precautions, revised 2012, indicated, Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection .Signs- The facility will implement a system to alert staff and visitors to the type of precaution the resident requires. 2. In an observation on 7/27/20 at 12:20 p.m., a cabinet which stored clean, reusable, white gowns to be used as PPE, was located in front of room [ROOM NUMBER]. In an observation and concurrent interview on 7/27/20 at 12:32 p.m., CNA 3 walked to the cabinet in front of room [ROOM NUMBER] to obtain a clean gown prior to entering room [ROOM NUMBER]. The DON and IP both stated all clean gowns were stored in the cabinet in front of room [ROOM NUMBER] for the entire hallway. In an observation and concurrent interview on 7/27/20 at 12:44 p.m., the AIT pointed to the cabinet in front of room [ROOM NUMBER] when asked where staff would go to obtain a clean gown prior to entering room [ROOM NUMBER]. A review of the facility's document titled Mitigation Plan, undated, indicated, Personal Protective Equipment .Necessary PPE will be made available directly outside of isolation rooms. 3. In an observation and concurrent interview on 7/27/20 at 12:25 p.m., the IP stated and demonstrated the following steps she expected staff to execute when donning (putting on) PPE prior to entering a room requiring droplet transmission based precautions (isolation). First conduct hand hygiene using alcohol-based hand sanitizer (ABHS), put on gloves, obtain gown from clean gown cabinet, then put on the gown. Since staff put on their N95 (specific type of mask to protect against droplet transmission of infection) mask, hair cover, and goggles or face shield at the beginning of their shift, they would not have to put those on immediately prior to entering the room. In an observation on 7/27/20 at 12:32 p.m., CNA 3 grabbed gloves from the PPE cart hanging on the door of room [ROOM NUMBER]. CNA 3 then obtained a clean gown from the cabinet in front of room [ROOM NUMBER]. CNA 3 walked back to stand in front of room [ROOM NUMBER] where she put on her gloves, then put on her gown prior to entering the room. In an observation and concurrent interview on 7/27/20 at 4:54 p.m., CNA 2 stated the first PPE she would put on were gloves prior to entering a room with droplet isolation. CNA 2 then walked to the end of the 200 hallway to read a sign, which indicated the correct order PPE should be put on. CNA 2 stated it would be helpful if the donning and doffing (taking off) sign was in front of the room door. In an interview on 7/31/20 at 4:39 a.m., the Unit Manager 1 (UM 1) stated she would don PPE in the following order prior to entering a droplet isolation room: conduct hand hygiene, put on gloves, put on N95 mask, and then put on the gown. UM 1 stated she would doff PPE in the following order prior to exiting the droplet isolation room: take mask off, then gown, then gloves, and sanitize hands. In an interview on 7/31/20 at 9:39 a.m., the Social Service Assistant (SSA) stated she would doff PPE in the following order prior to exiting a droplet isolation room: gown, eye protection, gloves,

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) and then mask. A review of the Center for Disease Control (CDC) guidelines for donning and doffing PPE, revised 7/14/20, indicated, Sequence for Putting on PPE: 1. Gown .2. Mask or Respirator .3. Goggles or Face Shield .4. Gloves .How to safely remove PPE Example 1: 1. Gloves .2. Goggles or Face Shield .3. Gown .4. Mask or Respirator .5. Wash hands or use an ABHS immediately after removing all PPE Example 2: 1. Gown and gloves (in exact order) .2. Goggles or Face Shield .3. Mask or Respirator .4. Wash hands or use an ABHS immediately after removing all PPE. A review of the facility's Mitigation Plan, undated, indicated, IP will .collect guidance from the .CDC and counsel staff on best practices to ensure consistent application of safe IP (Infection Prevention) practices. A review of the facility's SOP titled Emergency Preparedness Plan COVID-19, dated 3/18/20, indicated, Post CDC PPE handouts outside of each isolated room. 4,5,6. In an interview on 7/27/20 at 12:02 p.m., the Administrator (ADM) stated the 300 hallway was where residents quarantined. During an observation on 7/27/20 at 4:34 p.m., CNA 1 prepared to refill a resident's cup from room [ROOM NUMBER]. CNA 1 exited room [ROOM NUMBER] with trash from the room in the right hand and a white styrofoam cup in the left hand. As CNA 1 walked toward the nurse's station, she flipped open the lid of a large white trash bin using the fingers of her left hand and threw the trash in the bin. CNA 1 walked past two hand sanitizer dispensers without sanitizing her hands before reaching the nurse's station. CNA 1 refilled the styrofoam cup she brought out of room [ROOM NUMBER] with water from the dispenser located on top of the nurse's station counter. CNA 1 entered room [ROOM NUMBER] without sanitizing her hands and returned the cup with refilled water. After exiting room [ROOM NUMBER], CNA 1 walked back in and took down a used PPE gown from behind the door. CNA 1 then walked across the hallway and entered room [ROOM NUMBER] to collect the used PPE gown from behind the door. CNA 1 immediately walked to room [ROOM NUMBER] and retrieved another used PPE gown from behind the door. CNA 1 then carried the used gowns to the other end of the hallway and placed them in the soiled gown bin. In an interview on 7/27/20 at 4:38 p.m., CNA 1 verified she refilled the same cup the resident had already used with water from the water dispenser at the nurse's station counter. CNA 1 also stated she had not placed the used gowns in individual plastic bags prior to putting them in the soiled gown bin nor had she sanitized her hands before and after exiting each of the resident rooms. In an interview on 7/31/20 at 2:32 p.m., the IP stated she expected nursing staff to obtain a new, unused cup and fill it with water for residents on isolation when they asked for a refill. A review of the facility's policy and procedure titled Isolation-Categories of Transmission-Based Precautions, revised 1/12, indicated, Gloves and Handwashing: .Remove gloves before leaving the room and perform hand hygiene. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room Gown: .After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces. A review of the facility's Mitigation Plan, undated, indicated, Trash bins in the COVID and 14-day quarantine areas will be kept in the resident rooms allowing for the disposal of PPE.