STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055039	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN REHAB AND CARE CENTER	1630 N. EDISON STREET STOCKTON, CA 95204

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 observations, interviews, and facility policy and procedure (P & P) review, the facility failed to properly implement and maintain infection control practices associated with COVID-19 for a census of 81 when: 1. Surveillance screening was improperly implemented; 2. Proper infection control practices and hand hygiene were not followed while resident's soiled clothing was removed from a resident's room; 3. Facemasks were not worn properly, and 4. Cleaning and disinfecting policies were not followed for point-of-care resident equipment. These failures placed all residents and staff in the facility at risk of exposure to COVID-19 resulting in the spread of infection, with the potential of causing illness or death. Findings: 1. During an observation on 7/8/20, at 8:06 a.m., it was noted that the entrance to the facility was not locked. Upon entering the facility the COVID-19 surveillance screening area did not have personnel conducting COVID-19 surveillance screening (includes temperatures checks). During an interview on 7/8/20, at 8:20 a.m., in the COVID-19 screening area, the Rehab Coordinator (RC) entered the facility. The RC indicated she takes her temperature at the front and if no one is present she goes to the, Station, (nursing station). During an interview on 7/8/20, at 8:30 a.m., in the COVID-19 screening area with Licensed Nurse (LN) 1, LN 1 indicated staff filled out the screening questionnaire themselves. LN 1 further indicated a screener should be at the front and she did not know what time they came in and when they weren't present, the entrance should be locked. During an interview on 7/8/20, at 8:35 a.m., in the COVID-19 screening area with the Business Office Manager (BOM), the BOM indicated there is supposed to be someone there at the front door and if no one is there the front door should be locked. The BOM indicated the COVID-19 screening questionnaires are checked at the end of the day by the Quality person. During an interview on 7/8/20, at 8:43 a.m., in the COVID-19 screening area with the Director of Nurses (DON), the DON indicated the entrance should be locked until 8:30 a.m. During an interview on 7/8/20, at 9:20 a.m., with Certified Nurse Assistant (CNA) 1, CNA 1 indicated she is supposed to check her temperature and fill out and sign the COVID-19 screening questionnaire. CNA 1 indicated her shift started at 7:00 a.m. and indicated she had not filled out the COVID-19 screening questionnaire or taken her temperature prior to starting work. CNA 1 stated, I didn't do that today. During an interview on 7/8/20, at 10:11 a.m., with the Director of Nurses (DON), the DON indicated the Infection Preventionist (IP) checks the COVID-19 screening questionnaires. During an interview on 7/8/20, at 11:00 a.m., with the IP, the IP indicated the COVID-19 screening questionnaires are forwarded to her and the charge nurse for that shift should have checked to ensure COVID-19 screening questionnaires were filled out correctly. During a concurrent interview and record review on 7/8/20, at 11:55 a.m., with the IP, the IP confirmed that in June 2020, there were 57 instances where staff took their temperature and did not answer the COVID-19 screening questions. The IP confirmed nine instances during June 2020, where staff did not record their temperature on the COVID-19 screening questionnaire. The IP confirmed for July 6, 7 and 8, there were 14 instances when staff did not fill out the COVID-19 screening questionnaire and 3 instances when staff did not record their temperature. This included CNA 1 who did not take her temperature and fill out the COVID-19 questionnaire for July 8, 2020. During an interview on 7/28/20, at 10:12 a.m. with the DON, the DON indicated the screening questionnaires are not to be done independently as the facility has a COVID-19 screener. A review of the facility P & P titled, COVID 19, revised 5/22/20, indicated, Procedure .4. Infection Control Preventionist will initiate an initial 100% screening questionnaire to all staff and residents currently admitted and future admissions regarding COVID 19 signs and symptoms. 5. Screening questionnaires to all staff will be required at the beginning of each shift. This will include information if they currently have fever, shortness of breath, cough, etc. All staff member's temperature will be checked at the beginning of each shift. 2. During a concurrent observation and interview 7/8/20, at 9:45 a.m., Certified Nurse Assistant (CNA) 2 was observed exiting a resident's room, room [ROOM NUMBER], carrying soiled resident's clothing in her ungloved hands, against her scrubs with no barrier in between the soiled resident clothing and her clothes. CNA 2 was observed carrying the soiled clothing down the hall, past two resident's rooms and placing the soiled clothing in a laundry bin. CNA 2 stated, .I know I'm not supposed to carry dirty clothes against my body . CNA 2 did not perform hand hygiene after placing the soiled resident clothing in the laundry bin. CNA 2 was observed getting a pair of gloves, walking down the hall, past room [ROOM NUMBER], turning around and returning to room [ROOM NUMBER], donning the gloves and calling another CNA to assist her with moving a resident from a commode to a wheelchair. During an interview on 7/8/20, at 9:48 a.m., with CNA 2, CNA 2 confirmed she had soiled resident clothing in her ungloved hands and the soiled resident clothing was against her clothes as she walked down the hall, passing three resident rooms, to deposit soiled clothing in the laundry bin. CNA 2 confirmed she did not wash her hands after placing soiled clothing in laundry bin. CNA 2 confirmed that she did not perform hand hygiene until after the resident in room [ROOM NUMBER] was placed in a wheelchair. During an interview on 7/8/20, at 4:00 p.m., with the Infection Preventionist (IP), the IP stated, Staff should be performing hand hygiene before and after patient contact. The IP indicated staff should wear gloves when removing soiled linens and clothing from resident's rooms. The IP indicated staff should not have any, Dirty items, against their clothing and the laundry bin should be directly outside the residents room to place dirty items in. A review of the facility P & P titled, ISOLATION, (Undated), indicated, .PROCEDURES: I. Standard Precautions .H. Linen. 1. Handle, transport, and process used linen soiled with blood, body fluids, secretions, and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and that avoids transfer of microorganisms (small organisms, invisible to the naked eye, capable of causing disease and/or infection) to other residents and environments. A review of the facility P & P titled, HANDWASHING, (Undated), indicated,POLICY All employees are required to follow the handwashing procedure. The use of gloves does not take the place of handwashing .C. Handwashing is required but limited to the following: 1. Before and after every patient contact .5. After gloves or other PPE (personal protective equipment) is removed .Other aspects of hand care and protection. A. Glove use. 1. Gloves should be used as an adjunct to, not a substitute for, hand washing. 2. Gloves should be used for hand contaminating activities. Gloves should be removed and hands should be washed when such activity is completed, when the integrity of the gloves is in doubt, and between residents. Gloves may need to be changed during the care of a single resident . 3. During a concurrent observation and interview on 7/8/20, at 1:50 p.m., Certified Nurse Assistant (CNA) 1 and CNA 6, were observed wearing their facemasks below their nose on two occasions. CNA 6 stated, I put it down here, it was under my nose. During an interview on 7/8/20, at 2:10 p.m., with the Director of Staff Development (DSD), the DSD stated, Mask needs to be above the nose. We remind them (staff) in in-service. During an interview on 7/8/20, at 2:20 p.m., with the Director of Nurses (DON), the DON stated, Mask should always be above their nose. A review of the facility P & P titled, COVID 19, revised 5/22/20, indicated, Procedure .30. All staff shall wear cloth face cover or face mask if available when interacting with residents and impractical to keep 6 feet distance possible. PPE (personal protective equipment) is required only when in direct contact with suspected or identified with COVID-19. A review of the Center for Disease Control and Prevention (CDC) document titled, Preparing for COVID-19 in Nursing Homes, dated 6/25/20, indicated, Core Practices .Implement Source Control Measures. HCP (healthcare personnel) should wear a facemask at all times while they are in the facility. when available, facemasks are generally preferred over cloth face coverings for HCP

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) as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from other .Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required. 4. During an observation on 7/8/20, at 10:25 a.m., Certified Nurse Assistant (CNA) 2 removed a dry paper tissue from a box at the nurse's station and used it to wipe a thermometer and blood pressure cuff. She placed the items into a basket on the counter. CNA 2 then wiped a pulse oximeter (a device placed on a finger to check oxygen saturation levels) with the dry tissue and placed it on the nurse's medication cart. During an interview on 7/8/20, at 10:30 a.m., CNA 2 indicated she used the tissue to dry the equipment after cleaning them in the resident's bathrooms with water and a paper towel. CNA 2 indicated she cleaned the items this way for her last three residents. When asked if water was adequate to disinfect equipment between residents, CNA 2 stated, .No, it's not I guess . During an interview on 7/8/20, at 10:36 a.m., with Licensed Nurse (LN) 3, LN 3 indicated equipment needed to be disinfected between every resident with disinfectant wipes. During an interview on 7/8/20, at 3:30 p.m., with the director of nursing (DON), the DON indicated staff must clean medical equipment with a disinfectant every time it was used during resident care. Review of the facility policy, CLEANING, DISINFECTION, AND STERILIZATION no date, indicated, .Cleaning, disinfection .will be carried out on all inanimate objects which could, if contaminated, be implicated in the spread of infection .
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 interview and facility policy review, the facility failed to ensure residents, their representatives, and families were informed timely, when persons associated with the facility (staff or residents) were confirmed positive for COVID-19 (a disease caused by [MEDICAL CONDITION] which can result in severe illness and death) for a census of 81. This failure resulted in a lack of transparency from the facility, which had the potential for residents, their representatives, and families to experience uncertainty about the status of illness in the facility and the effect it could have on them. Findings: During an interview on 7/8/20, at 9:30 a.m., Resident 9 stated, .No one told me there were any COVID positive here. I did not know that. I figured with all the plastic stuff (barriers and gowns worn by staff) there was something going on . During an interview on 7/8/20, at 10:10 a.m., Resident 10 stated, .No one said anything to me about positive people. I just have to look around to see what's going on . During an interview on 7/8/20, at 10:38 a.m., Resident 11 stated, .No one told me if they (facility) have positive cases (of COVID-19) .I asked them . Resident 11 indicated he learned of the cases in the facility the day before, on 7/7/20, six days after the first tests were confirmed positive for COVID-19. During an interview on 7/8/20, at 10:44 a.m., with Licensed Nurse (LN) 2, LN 2 stated, .I'm not sure of how they (residents) are notified of positive (COVID-19) tests . During an interview on 7/8/20, at 11:32 a.m., with the facility administrator (ADM), the ADM indicated the residents who required room changes were notified when there were positive COVID-19 results which required a move to another unit. The ADM indicated there was no designated staff member responsible for notifying all residents in the facility. During an interview on 7/8/20, at 11:39 a.m., with the infection preventionist (IP), the IP indicated the facility nurses notified the residents who tested positive for COVID-19, as well as their family. The IP was not sure what method was used to notify all the other residents in the facility. During an interview on 7/8/20, at 11:50 a.m., with the social services assistant (SS), the SS stated, .The nurses are supposed to tell the residents (of positive COVID-19 tests) so they (residents) won't go from one station to another . During an interview on 7/8/20, at 12 p.m., with the director of nursing (DON), the DON indicated the facility received the first positive COVID-19 test results on 7/1/20. The DON indicated nursing staff notified residents who received a positive COVID-19 test as well as those who needed to be moved to a different room. She was not able to confirm whether all residents were notified when a resident or staff member received a positive test. During a subsequent interview on 7/8/20, at 3:30 p.m., the DON indicated Resident 9, Resident 10, and Resident 11 should have been informed when positive cases of COVID-19 occurred in the facility. Review of the facility policy titled Coronavirus Disease 2019 (COVID-19) Mitigation Plan for Skilled Nursing Facilities not dated, received by the state agency on 6/10/20, indicated, .COMMUNICATION .The facility will inform families and responsible parties .in case of identification of Covid-19 cases .by 5pm, the day after a case of Covid-19 has been confirmed .A designated Infection Control support staff will send out letters, make phone calls to families and staff and inform residents directly .