STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056037	A. BUILDING _____ B. WING _____	04/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PACIFIC HILLS MANOR	**370 NOBLE COURT MORGAN HILL, CA 95037**

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 did not follow infection control and preventions techniques including proper use of face masks, hand hygiene, surface sanitization, and proper placement of one of 2 residents (R1) on transmission based precaution. Although the facility did not have any active or presumptive COVID-19 positive cases, these deficient practices had the potential to spread infections to residents and staff in the facility. Findings: 1. During the initial tour of the facility on 4/1/2020 beginning at 9 AM, while in the lobby Staff U walked through the lobby with a face mask that covered only his mouth. In another hallway, two CNAs (Staff V and Staff W) were observed in an unsampled resident's room providing personal care to a resident. Both of the CNAs had face masks on that covered only their mouth. When asked if they were trained how to wear the face masks, the two CNAs said they did; however the mask made their nose itch. The face masks worn by the above personnel were surgical masks. Several staff also wore home made masks. These masks did not fit well and slipped down often, causing staff to repeatedly touch the outside of these masks without follow up hand hygiene. This put the staff at risk of contaminating their hands. On 4/1/2020 in the afternoon, during an interview with the Infection Control Preventionist (ICP) when asked about the above observation she stated that the masks should be worn covering both the nose and the mouth. 2. During initial tour observations on 4/1/2020 beginning at 9 AM, Resident's (R4) room had a sign on the door indicating transmission based precautions (TBP - also known as isolation). R4 was in a room by him/herself. When asked why R4 was on TBP and what type of TBP was in place, Staff 3 stated R4 had [DIAGNOSES REDACTED]. Diff. a contagious intestinal infection that causes severe diarrhea) and was on Contact Precautions. Staff D stated that when staff went into the room to care for the resident they should put on a gown and gloves. During observations on 4/1/2020 at 11:52 AM, Staff 15 was observed in R4's room. Staff 15 had on a cloth gown and gloves. Just before Staff 15 came out of the room she removed her gloves, threw them in the trash in the resident's room and then removed her gown. She rolled up the gown and then brought it out of the room to look for a soiled linen cart in which to place the soiled gown. Staff hospitality aide (HA) was leaning on the soiled linen cart and saw that Staff 15 needed it so pushed it to her. Staff HA opened the lid with her ungloved hands and Staff 15 tossed the soiled gown into the cart. Staff 15 then went down the hall to the nurses station to wash her hands. While this was going on a CNA in the room next to R4's room brought out an armful of soiled lined and looked for the soiled linen cart. Staff HA pushed the cart to her and the CNA stepped on a lever that opened the lid and tossed in the soiled linen. Staff HA then pulled the cart back, opened the lid with her bare hands and pushed the soiled linens down into the cart with her bare hands. Staff HA then went into the room next to R4's room and pulled a resident's overbed table out of the room. Staff HA had not performed hand hygiene after handling the soiled linen and soiled linen cart. When asked about this, Staff HA removed a small bottle of alcohol based hand rub (ABHR) from her back pocket and rubbed the substance on her hands. She then started to push the overbed table back into the room. When asked who was responsible to sanitize the overbed table, Staff HA poured hand sanitizer on a tissue and began to rub the edge of the table. The surveyor asked Staff HA to stop and not to place the overbed table back in the resident's room. The surveyor went and got the DON to observe, told him her observations. The DON watched the Staff HA for a moment and then said that Staff HA was not supposed to assisting with any resident care. He immediately removed Staff HA to do one the spot training. He asked the nurse supervisor who was nearby to sanitize the overbed table. The DON stated Staff HA was brand new and had only been there for two days. She had not yet finished her infection control training yet. During an interview regarding the above observation with the ICP later that afternoon, she stated the staff should place soiled linen in a plastic bag in the room before placing it in the soiled linen cart. The staff should wash their hands in the resident's bathroom before leaving the room. 3. During initial tour observations on 4/1/2020 beginning at 9 AM, R1's room had a sign on the door indicating transmission based precautions(TBP) (isolation) were in place. There were three resident's in this room; R1, R2 and R3. When asked which one was on TBP, what type of TBP was in place and the reason for the TBP, Staff I stated R1 was on contact precautions for shingles. R1 has had them since 3/17/2020. The rash covered the resident from the left side front of the chest, under the arm and around to the mid back. The vesicle were dried up except for a few open areas on her back. They do wound treatment and cover them with a dressing every day. When asked if all of the vesicles had been covered the entire time the resident had the disease, Staff I stated, No. The area was too large at first. When asked how long the vesicles were weeping (oozing fluid) (The disease is contagious while the vesicles are weeping) Staff I stated for the first 3-4 days after she was treated with Acyclivir ([MEDICAL CONDITION] medication.) R1 had [DIAGNOSES REDACTED]. Defined by the CDC as Shingles is a [MEDICAL CONDITION] infection that causes a painful rash. Although shingles can occur anywhere on your body, it most often appears as a single stripe of blisters that wraps around either the left or the right side of your torso. Shingles is caused by the [MEDICATION NAME]-[MEDICATION NAME] virus - the [MEDICAL CONDITION] that causes chickenpox. The three residents in R1's room were on hospice, were elderly and had illnesses that made them vulnerable to infections. R2 [MEDICAL CONDITION] with metastasis (spread of [MEDICAL CONDITION]) to the bone and was nearest to R1. None of the residents were independently mobile. The room was set up as follows: The head of the beds were against the wall on the left as you entered the room. R3 was in the bed near the door. R2 was in the middle bed. R1 was in the bed near the window; however the side of R1's bed was pushed against the wall on the left a you entered the room. The head of R1's bed was perpendicular and between two to three feet of the head of R2's bed with a privacy curtain between them. Observations throughout the day showed that staff entered the room without PPE on unless they were taking care of R1. They would put on a gown and gloves to care for R1. On 4/1/2020 in the afternoon, during an interview with the Staff C when shown R1's room and R1's position in the room and nearness to R2, Staff C stated their beds were too close. When asked if R2 was at risk of getting shingles and what the potential out come could be for her Staff C stated, R2 [MEDICAL CONDITION] and could get shingles. She stated that the outcome for the resident could included painful rash and possible nerve pain. Review of the medical records of R1, R2 and R3 included a screening for shingles (at admission) and indicated that they had either been exposed to, had the vaccine or had chicken pox. Review of the staff (who took care of R1 during this survey) employee files revealed that the facility screened staff for chicken pox and offered them vaccines if they had not had the disease. Review of the CDC guidance on TBP recommended for people with Shingles ([MEDICATION NAME] virus) included the following: III.B.1. Contact precautions A single-patient room is preferred for patients who require Contact Precautions. When a single-patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). In multi-patient rooms, (greater than or equal to) 3 feet spatial separation between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients . The potential outcome to residents who get shingles include the following: Complications from shingles in the elderly can lead to serious, long-term health problems. They range from bacterial skin infections that can cause scarring and narcotizing fasciitis to hearing and vision loss, encephalitis, [MEDICATION NAME] [DIAGNOSES REDACTED], peripheral motor [MEDICAL CONDITION], and postherpetic neuralgia (PHN (severe nerve pain)). On

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) 4/2/2020 during observations in the morning, the facility had changed the position of R1's bed so that it was more than three feet from R2. Staff were wearing masks properly and using proper hand hygiene. Observations of staff caring for R4 revealed proper use of PPE and disposal of soiled linens as well as proper surface sanitization.