STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055084	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CENTRAL VALLEY POST ACUTE	2649 TOPEKA STREET RIVERBANK, CA 95367

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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 failed to implement and maintain a safe environment with an effective prevention and control program for the prevention of Coronavirus (COVID-19-a new highly transmissible severe respiratory virus) transmission when: 1. One of 43 Residents (Resident 10) was observed in the Yellow Zone (an area in the facility that was designated as an observation unit for residents that are exposed to someone infected with COVID-19 or who is symptomatic for COVID-19), and was permitted to wander unsupervised through the facility and did not wear a protective face covering over his mouth and nose and was not redirected to wear a protective face covering per the facility's policy titled, [MEDICAL CONDITION] Disease 2019 (COVID-19) Mitigation Plan and Centers for Disease Control and Prevention (CDC) guidance for universal face coverings in health care facilities; 2. Staff did not store their dedicated N-95 respirator (a device to protect the wearer from inhaling chemicals and infectious (likely to spread infection) particles) according to CDC guidelines, titled, Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Face piece Respirators in Healthcare Settings; 3. The facility used portable cooling equipment in the resident area hallways blowing air into the environment while the residents' doorways were open to the hallways; 4. Oscillating fans (a type of fan that swings or rotates) were placed in hallways and resident rooms 15, 20, 21, and 31, and resident room doors in the yellow zone were open; 5. The facility maintained two separate red zones (isolation area for COVID-19 positive residents) for the care of COVID-19 positive residents and staff were permitted to go between the red zones and other areas of the facility against the CDC standards for cohorting and maintenance of physical barrier; and 6. The facility did not employ a certified infection preventionist (professional who ensures healthcare workers and patients are doing all the things they should to prevent infections). These practices potentially placed the residents and staff at risk for the spread and transmission of COVID-19. Findings: 1. During a concurrent observation and interview on 8/14/20 at 8:55 a.m., with the Director of Nursing (DON), in C Unit Hallway, Resident 10 was observed walking back and forth between his room (room [ROOM NUMBER]) and Unit A's nurse's desk. Resident 10's facemask was around his neck, the facemask did not cover his mouth or nose. The DON reminded Resident 10 to put his mask over his mouth and nose. Resident 10 continued to walk toward room [ROOM NUMBER], without adjusting his mask to cover his nose and the DON did not take any further action to assist Resident 10 to cover his mouth and nose with his mask. The DON stated staff try to get Resident 10 to wear his mask over his mouth and nose, however Resident 10 becomes aggressive when staff attempt to get him to quarantine in his room. The DON stated she was not sure if one to one activity had been offered to Resident 10 to assist with quarantining to his room. During a concurrent review of an untitled document (Line List) (this document is designed to be used as a line list template for investigations of outbreaks of unexplained respiratory illness), dated 8/19/20, the Line List indicated Residents 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, and 42 were tested for COVID-19 on 8/11/20. The COVID-19 test results for Residents 10 through 42 indicated positive for the COVID-19 virus. During a concurrent record review and interview on 8/19/20 at 12:40 p.m., with the Assistant Administrator (AADM), the Line List indicated 33 of 48 residents who were roomed in the Yellow Zone tested positive for COVID-19 from the lab drawn on 8/11/20. The AADM validated Resident 10 was the resident who was not wearing his mask over his mouth and nose and was wandering the C unit hallway on 8/14/20. During a concurrent interview and record review, on 8/18/20 at 3:35 p.m. with the Administrator (ADM), the ADM validated the facility's document titled, [MEDICAL CONDITION] Disease 2019 (COVID-19) Mitigation Plan, along with the associated infection control policies were updated on 8/11/20, and the Mitigation Plan defined the facility's current infection control practices based on CDC recommendation related to COVID-19. During a professional reference review retrieved on 8/31/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html titled, Preparing for COVID-19 in Nursing Homes, dated 6/25/20, indicated, . Given their congregate (opportunities to share activities of daily living with others) nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens (bacteria or virus) like COVID-19 .Core Practices .Implement Source Control Measures .Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room .Definitions: Source Control: Use of cloth face covering or facemasks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing . During a review of the facility's document titled, [MEDICAL CONDITION] Disease 2019 (COVID-19) Mitigation Plan, undated, the [MEDICAL CONDITION] Disease 2019 (COVID-19) Mitigation Plan indicated, .Restriction of Congregating Residents .Policy Interpretation and Implementation .3. Those residents that are not able to stay inside their rooms must be monitored and practice social distancing of being at least 6 feet away from other residents .Person Under Investigation .1. Place PUI's (Persons Under Investigation) with or without respiratory symptoms .in an isolation room .for 14 days. Close Door after leaving the patient's room. Resident .the patient must wear surgical mask .the patient will continue to wear a surgical mask for a period of 14 days or until symptoms persist . The [MEDICAL CONDITION] Disease 2019 (COVID-19) Mitigation Plan signature page, dated 8/11/20, indicated, .By signing this Original Review and Approval log each attendee agrees to and understands the set forth COVID-19 mitigation plan. The signature page was signed by the Administrator, AADM, DON, Dietary Manager (DM), Social Services Manager (SSM), Staffing Coordinator (SC), and Housekeeping Supervisor (HS). 2. During a concurrent observation and interview on 8/14/20 at 4:35 p.m., with Licensed Vocational Nurse (LVN) 1, B unit's clean supply, medication closet was observed. There was a used N-95 respirator in a paper bag on top of a metal supply rack. LVN 1 stated the handwritten name on the paper bag was LVN 3. LVN 1 stated he did not know why the used N-95 respirator was in the clean storage closet. LVN 1 stated he wore an N-95 respirator at all times in the facility, reuses the mask for three shifts, and stores his used N-95 respirator in a sealable plastic bag. LVN 1 stated he was aware used N-95 respirator masks were to be stored in a paper bag but he did not have one so he used a plastic bag. LVN 1 stated he would take his N-95 respirator mask home at the end of the shift and sometimes he would leave it in the clean supply and medication closet. During an interview on 8/14/20 at 4:40 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated he was required to wear an N-95 respirator and face shield at all times while in the facility. CNA 1 stated he reuses his mask for five days, stores it in a sealable plastic bag, and sprayed it with (Brand Name) disinfectant between uses. CNA 1 stated at the end of each shift, he would leave his used N-95 respirator in the clean supply and medication closet. During an interview on 8/14/20 at 5:10 p.m., with LVN 2, LVN 2 stated staff stored their used N-95 respirator in a paper bag in the supervisor's office and the facility staff did not have a designated area to store their N-95 respirator at the end of the shift. During an interview on 8/14/20 at 6:10 p.m. with the DON, the DON stated N-95 respirators could be reused for up to five shifts, staff should not take their used N-95 respirators home, and staff were required to store their used N-95 respirators in a paper bag at the facility. The DON stated there was no designated space in the facility for staff to store their used N-95 respirators. During a professional reference review retrieved on 8/20/2020 from https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html, titled, Recommended Guidance for Extended Use and Limited Reuse of N95 Filtering Face piece Respirators in Healthcare Settings, dated 3/27/20, indicated, .Respirator

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) Reuse Recommendations . Hang used respirator in a designated storage area or keep them in a clean, breathable container such as a paper bag between use. To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly . 3. During an observation on 8/14/20 at 10:45 a.m., in C unit in the yellow zone, four portable swamp coolers (movable equipment that blows out and cools the air) were in the hallway against the wall between room [ROOM NUMBER] and the Conference Room. A portable hepa filter machine (movable equipment that draws in and cleans the air) was located in the hallway outside the doorway of the conference room. The swamp coolers and the hepa filter machine were expelling air into the hallway. During an interview on 8/14/20 at 11:20 a.m., with the ADM, the ADM stated recently, the main air cooler that serviced the hallway was broken and was repaired on or about 8/11/20. The ADM stated maintenance staff were still checking to ensure the repairs were effective and due to the anticipated heat wave, swamp coolers were placed in the hallway. The ADM stated they had placed the hepa filter machines in four areas (A unit, B unit, B isolation unit, and C unit) in the facility to clean the air to decrease the risk for transmission of COVID-19. The ADM validated the swamp coolers and the hepa filters in the C unit hallway were expelling air into the environment. During an observation on 8/14/20 at 4:50 p.m., of B unit hallway, a plastic barrier curtain extended from the ceiling to the floor between rooms [ROOM NUMBERS] was observed. The plastic barrier curtain had a red vertical zipper through the center of the curtain. The barrier curtain was not secured at the bottom, the curtain was bulging out toward room [ROOM NUMBER] and B unit hallway, and a humming noise was heard on the other side of the barrier curtain. During an interview on 8/14/20 at 4:55 p.m., with LVN 1, LVN 1 stated she was the nurse caring for patients on the other side of the barrier curtain and the area was considered a red zone (area where COVID-19 positive residents were placed). LVN 1 stated there was a machine in the red zone near the barrier curtain and the machine was blowing air into the environment and that was what made the barrier curtain bulge. LVN 1 stated she did not know why the machine was there or what it was used for. During an interview on 8/14/20 at 6:10 p.m., with the DON, the DON validated that portable swamp coolers and portable hepa filters had been placed in the hallways on A, B, and C units. The DON stated the portable swamp coolers had been removed earlier and she did not know what time or why they were removed. The DON stated .I might have mentioned it to them (spoke to maintenance staff), but I'm going to defer all questions about the hepa filters and swamp coolers to maintenance . During a concurrent observation and interview on 8/14/20 at 6:10 p.m., with the ADM, of the isolation barrier curtain in B unit hallway, the isolation barrier curtain used to separate the isolation area (red zone with COVID-19 positive residents) was bulging toward the non-isolation area and there was a approximately a two inch (inches-unit of measurement) gap at the bottom of the curtain. The ADM validated the curtain was bulging, there was a two inch gap at the bottom and there was a humming noise from a machine on the opposite side. The ADM stated the humming noise was coming from a swamp cooler. During a professional reference review retrieved on 8/20/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html dated 7/15/2020 titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic (an outbreak of a disease over a whole country or the world) indicated, .2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection . Patient Placement If admitted , place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection .with the door closed. 4. During an observation on 8/14/20 at 4:20 p.m., of A unit hallway, room [ROOM NUMBER] had a two ft. (feet - a unit of measure, one foot is equal to 12 inches) by two ft. (approximate) oscillating fan sitting on the floor at the end of bed A. The cord to the fan extended into the hallway and was plugged into an electrical outlet outside and to the left of the doorway. The fan was blowing air toward bed A and the setting was on the high setting. In unit A, resident rooms 11, 12, 13, 14, 15 and 16 were open. The DON and staff on A unit were not available for interview at the time of the observation. During an observation on 8/14/20 at 4:25 p.m., of C unit hallway, room [ROOM NUMBER] had a standing oscillating fan at the at the foot and between beds A and B. room [ROOM NUMBER] had a standing oscillating fan at the foot of bed B and between beds A and C. Both fans were blowing air towards the residents' beds. In unit C, resident rooms 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27 were open. The DON and staff on C unit were not available for interview at the time of observation. During an observation on 8/14/20 at 4:30 p.m., of B unit hallway, room [ROOM NUMBER]'s door was open and inside was a square white fan on the floor. The fan was turned on and blowing air. During an observation on 8/14/20 at 4:40 p.m., of the hallway between units B and C, there was a standing round oscillating fan at the end of the hallway, a large round orange fan on the floor approximately halfway down the hallway, and a standing fan inside resident room [ROOM NUMBER]. During an interview on 8/14/20 at 6 p.m., with the DON, the DON stated she was aware there were portable oscillating fans in some of the resident's rooms, she did not know which rooms had oscillating fans. The DON stated they generally did not close the doors to resident rooms unless staff were providing care or the resident requested it. The DON stated she did not know how many rooms had their doorways open while the oscillating fans and swamp coolers were blowing air into the environment. During a professional reference review retrieved on 8/20/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html dated 7/15/2020 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 . Patient Placement If admitted , place a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection .with the door closed . 5. During a review of the facility map, the map indicated unit A's rooms one to 10 were a Red zone. Rooms 11- 16, all of Unit C's rooms 17 to 27, and Unit B's rooms 28 to 33 were a Yellow zone. Unit B's rooms 34 to 40 were identified as a second Red zone. During an observation on 8/14/20 at 10:30 a.m., a facility tour was conducted. Unit A had a barrier curtain to section off rooms one to 10. All of unit C's rooms, 17 to 27 were open and had no barrier curtain. Unit B had a barrier curtain to section off rooms 34 to 40. During an interview on 8/14/20 at 10:40 a.m. with the DON, the DON validated there were two Red zones, one at the end of each hallway on Units A and B. The DON stated when resident's COVID-19 test results were returned and were positive, it seemed like it was happening on both ends of the facility and instead of moving COVID-19 positive resident through the hallway where residents did not have COVID-19, it was better just to make two Red zones. The DON stated staff caring for COVID-19 positive residents were not permitted to enter the Yellow zone or other areas of the facility. The DON stated, zippers in the isolation barrier curtains were used to pass supplies and meal carts to the Red zones, there was no person to person contact, and staff were required to close the zipper immediately. During an observation on 8/17/20 at 11:30 a.m., the isolation barrier curtain separating the Red zone from the Yellow zone between Units B and C was unzipped. The housekeeping closet located next to the isolation barrier curtain was open and a housekeeping cart was next to the door and the unzipped barrier. There were no staff in the area. During a concurrent observation and interview on 8/17/20 at 11:35 a.m., Housekeeper (HK) 1 walked from the Unit C hallway and into the Unit B's hallway next to the isolation barrier curtain, entered the housekeeping closet and pulled the housekeeping cart into the closet. HK 1 exited the closet and pulled the isolation barrier curtain closed. HK 1 stated she did not know why the isolation barrier curtain zipper was open or who had opened it. HK 1 stated the isolation barrier curtain should be zipped closed at all times to prevent the spread of COVID-19. During a concurrent interview and record review on 8/18/20 at 3:35 p.m. with the ADM, the ADM validated the facility's document titled, [MEDICAL CONDITION] Disease 2019 (COVID-19) Mitigation Plan, along with the associated infection control policies was updated on 8/11/20 and the mitigation plan defined the facility's current infection control practices based on CDC recommendation related to COVID-19. During a review of the facility's document titled, [MEDICAL CONDITION] Disease 2019 (COVID-19) Mitigation Plan, undated, the [MEDICAL CONDITION] Disease 2019 (COVID-19) Mitigation Plan indicated, .Designated Isolation/COVID-19 Units (Red/Yellow and Green Zones) Each zone is separated by an anti-stat flame retardant barrier. To pass through a barrier a zipper is installed to allow controlled opening and closing between each zone. Between the Yellow and Red zone a double barrier has been made creating an intermediate area for safe staging and passing of supplies with no direct person to person interactions. Once materials are staged for the Red zone in the intermediate staging area employees from the yellow zone will leave and seal the staging zone. Red zone team members can then access the zone to receive supplies and reclose the intermediate zone after exiting . During a professional reference review retrieved on 8/31/20 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html dated 4/20/20, titled, Responding to Coronavirus (COVID-19) in Nursing Homes indicated, .Determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit .Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) already infected) .Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19 .Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms .Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility . During a professional reference review retrieved on 8/20/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html titled, Preparing for COVID-19 in Nursing Homes Infection Control for Nursing Homes, dated 6/25/20, indicated, .Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with COVID-19. Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19. Identify HCP (health care personnel) who will be assigned to work only on the COVID-19 care unit when it is in use . 6. During an interview on 8/19/20 at 12:20 p.m. with the AADM, the AADM stated the facility's designated Infection Control Preventionist (ICP) had not completed the required exam to become certified as the ICP for the facility. The AADM stated he was aware of the requirement for the facility to have a certified ICP. The facility did not provide any documentation to indicate their designated ICP had obtained the required certification. During a professional reference review retrieved on 8/31/2020 from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html titled, Preparing for COVID-19 in Nursing Homes, dated 6/25/20, indicated, .Facilities should assign at least one individual with training in IPC (infection prevention and control) to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices .