STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056153	A. BUILDING _____ B. WING _____	**06/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NAPA POST ACUTE	**705 TRANCAS ST. NAPA, CA 94558**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 maintain proper infection control protocols when: 1) The facility had no quarantine area to observe newly admitted and readmitted residents for signs of infection, 2) staff did not perform hand hygiene in situations where hand hygiene was necessary to prevent cross contamination, 3) medical equipment that was used for multiple people living in different areas of the facility was not cleaned or sanitized before it was put back in use. These failures had a potential to introduce and spread COVID-19 to all 108 residents, staff and essential visitors. Findings: During the entrance interview, on 5/27/20, at 2:35 p.m., with the administrator and the Director of Nursing (DON), they stated they were screening new residents and previous residents for admission. The administrator stated eight residents had been admitted in the past 14 days. The administrator stated he was aware of the risk for outbreak of coronavirus or COVID-19. The administrator stated there had been zero cases or possible cases of COVID-19 at the facility. He stated the facility had followed all the federal, state, and local requirements to safely admit residents into the facility. The administrator stated the facility had an observation area at the end of the West Hall where the admitted residents would reside until it was determined they did not have the coronavirus. The administrator stated when a resident was identified as COVID-19 negative, that resident would be moved into any available room throughout the facility. During an observation, on 5/27/20, at 2:40 p.m., in the West Hall, there was a plastic panel spanning the width of the hallway. The panel was attached at the physician's lounge on one side and room [ROOM NUMBER] on the other side. The panel hung from the ceiling to the floor and had a zipper in the middle. During an interview, on 5/27/20, at 2:42 p.m., with the administrator, he stated they put up the panel to separate the observation area and the rest of the facility. The administrator stated admitted residents would be placed in the observation area under quarantine until they were ready to be moved. During an observation, on 5/27/20, at 2:45 p.m., in front of Nurse Station 1, Resident 1 was sitting in a wheelchair. Resident 1's face mask was untied and hanging around his neck. Both his nose and mouth were exposed. Resident 1 stood up and took one shuffled step, Staff A and Staff B intervened. They supported Resident 1's arms with their arms and assisted him back to his wheelchair. No personal protective equipment (PPE) was worn be either staff. Staff B wheeled Resident 1 past the panel barrier into the designated quarantine area. The zipper panel remand unzipped. Staff B exited the quarantine area and walked to the medication administration cart. No hand hygiene was observed. During an observation, on 5/27/20, at 2:50 p.m., in front of Nurse Station 1, Staff C and Staff D emerged from the quarantine area and walked to toward the lobby. Staff C continued without performing hand hygiene. The panel was left unzipped. During an observation, on 5/27/20, at 2:55 p.m., in front of Nurse Station 1, Staff E wheeled Resident 1 out of the quarantine area. Staff E did not perform hand hygiene. Staff E continued to ambulate with Resident 1 in the wheelchair. Resident 1 was not wearing a face mask. Staff E walked past the kitchen and onto the East Hall. Staff E proceeded down the East Hall to Nurses Station 2 and turned towards the facility lobby. Staff E continued down the West hall to an unknown location. During a concurrent observation and interview on 5/27/20, at 3 p.m., with the Director of Staff Development (DSD), in front of Nurse Station 1, the plastic panel was observed to be unzipped. The DSD stated she was not sure if their policy was to keep the panel zipped or unzipped. The DSD stated the area beyond the plastic panel was for newly admitted residents who were being monitored for any symptoms of COVID-19. The DSD stated the zippered panel served as the entrance and exit for staff and residents. The DSD stated all residents were required to have a COVID-19 negative test prior to admission. No timeframe was given for the negative result and the actual date of admission. The DSD stated the facility was not using designated staff for that area. The DSD stated there was no separate dedicated supplies stocked in that area. When asked about the 3 medication administration carts parked at Nurse Station 1, the DSD confirmed one cart was pushed in and out of the quarantine area as needed. The DSD stated the night shift nurse and certified nurse assistants (CNA) would need to provide care to both the quarantine area and a few rooms in the West Hall. The DSD confirmed the area was not on any enhanced precautions above the standard precations. During an interview, on 5/27/20, at 3:05 p.m., with the DSD, she stated the facility expectation after exiting the quarantine area was to completely zip the zipper to the ground and then proceed to the hand washing sink located at Nurse Station 1. The DSD stated residents were allowed to leave the quarantine unit to attend therapy, in the gym, which was located on the East hall. During a concurrent observation and interview on 5/27/20, at 3:06 p.m., with the DSD, witnessed Staff F walk out of the quarantine area and no hand hygiene was performed. Staff F entered a door labeled clean utility. Staff F walked out of the room with two basins and assorted hygiene supplies. Staff F entered the quarantine area via the unzipped plastic barrier. The DSD stated Staff F's actions did not meet the facility's expectation. During an observation, on 5/27/20, at 3:08 p.m., in front of Nurse Station 1, Staff N emerged from the quarantine area and removed clean linen from a cart in the hallway. Staff N returned to the quarantine area. No hand hygiene was observed. During an observation, on 5/27/20, at 3:10 p.m., in front of Nurse Station 1, Resident 2 walked through the unzipped plastic barrier from the quarantine area to Nurse Station 1. Resident 2 was not wearing a face mask. Resident 2 announced he needed pain medication. Resident 2 spoke to two nurses and neither offered a mask to Resident 2. Resident 2 stood at Nurse Station 1 until Staff M asked him to go back to bed at 3:12 p.m. During an observation, on 5/27/20, at 3:14 p.m., in front of Nurse Station 1, Staff I exited the quarantine area and picked up a face mask from Nurse Station 1. Staff I walked into the quarantine area, no hand hygiene was observed. During an observation, on 5/27/20, at 3:15 p.m., in front of Nurse Station 1, a machine that provided oxygen therapy and a (brand) medical lift to assist with transferring residents were pushed out of quarantine unit into the facility by Staff O and Staff Q. Neither piece of medical equipment was cleaned or disinfected after exiting the quarantine unit. Staff Q pushed the oxygen concentrator down West hall towards the lobby. The DSD stated she needed to stop what she saw and followed Staff Q to intervene. During an observation, on 5/27/20, at 3:17 p.m., Staff O pushed the (brand) medical lift down a hallway and into the dining room to store. The lift was not cleaned or disinfected. During an interview, on 5/27/20, at 3:21 p.m., in front of the dining room, the DSD entered hallway and stated she stopped the oxygen concentrator from going back into use. The DSD confirmed her intervention was to prevent further cross contamination between the current residents of the facility and the newly admitted residents in the quarantine area. During an interview, on 5/27/20, at 3:23 p.m., in front of Nurse Station 1, with Staff Q she stated the medical equipment had been used in the quarantine area. Staff Q stated the equipment was being put back to the normal storage places when not in use. Staff Q stated Central Supply staff were responsible for cleaning the medical equipment. During an observation, on 5/27/20, at 3:25 p.m., in front of Nurse Station 1, Resident 1 had his face mask around bottom of his chin. Both his nose and mouth were exposed. Resident 1 was sitting in his wheelchair. Resident 1 stood up, ambulated approximately three feet to the medication administration cart. Resident 1 reached out and grabbed the medication cups stacked on the cart. Multiple staff intervened and assisted Resident 1 to his chair. Staff T wiped the flat surface of the cart with one disinfectant wipe and walked away. Staff T did not wait the manufacturer's required number of minutes (of wet time) to ensure the area stayed wet for complete disinfection. No other surface was wiped down. The plastic medication cups were not removed from the cart. During an observation, on 5/27/20, at 3:26 p.m., in

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) front of Nurse Station 1, the plastic panel was almost completely unzipped. Licensed Staff D entered the quarantine area and then emerged a few minutes later. No hand hygiene was observed. During a concurrent observation and interview on 5/27/20, at 3:29 p.m., with Staff Q, she was transferring medical equipment and personal items from the quarantine area to a room on the West hall. No PPE (personal protective equipment) was observed. Staff Q stated there was a new admission scheduled so a resident was moving out of the quarantine room. Staff Q confirmed all items were being transferred from the quarantine area to the new room. A mattress was removed from the quarantine area by 2 staff and carried down the West hall. The mattress was left unattended, leaning on the wall, in West hallway. During an interview, on 5/27/20, at 3:33 p.m., with the DSD, she stated the isolation/quarantine policies were in the process of being updated to match the most recent recommendations. The DSD stated she would have the first version created at onset of the COVID-19. The DSD was not aware of a procedure for admission during the COVID-19 pandemic. She deferred to the administrator for a formal response. During a concurrent observation and interview, on 5/27/20, at 3:35 p.m., in front of Nurse Station 1, Resident 3 walked up to the DSD with mask on his chin. The DSD stated the facility required the face mask to be on his face covering his mouth and nose. Resident 3 stated he was a new admit residing in the quarantine area. Resident 3 stated he was at this facility for physical therapy. Resident 3 stated he went to the gym for therapy often. Resident 3 stated all staff have masks and some wore gloves. Resident 3 stated he had never seen any staff wearing a protective gown or a face shield at this facility. Resident 3 described a blue plastic disposable gown and full-face shield worn by the staff at the acute hospital he was at prior to his admission. The DSD reviewed the medical record for Resident 3 and stated he was admitted for physical therapy after having surgery. Resident 3 was cognitively intact with no memory issues. During a concurrent observation and interview, on 5/27/20, at 3:37 p.m., with the DSD, we looked through the open zipper of the plastic panel that separated the quarantine area from the rest of the facility. There were no PPE supply carts visible. There were three staff visible in the quarantine area. None of them were wearing any additional PPE. Two of the three staff were wearing face masks that did not protect them from COVID-19. There was no signage to indicate any form of precautions should be taken in the quarantine area. The DSD confirmed contact precautions were not followed. The DSD had no answer when asked why contact precautions were not carried out for newly admitted residents with an unknown COVID-19 status. During a concurrent observation and interview, on 5/27/20, at 3:40 p.m., Resident 1 was in his wheelchair at Nurse Station 1. Resident 1 was not wearing a face mask. The DSD Confirmed his room was in the quarantine area. The DSD stated Resident 1 was placed at Nurse Station 1 because he required supervision. The DSD stated there was no nurse station in the quarantine area, so there was no central location to place Resident 1 in his area. The DSD had remained present throughout the observation and interview period from 3 p.m. to 3:40 p.m The DSD stated she needed time to gather facility policies and procedures. She exited the observation area. During an observation, on 5/27/20, at 3:41 p.m., Resident 4 ambulated via wheelchair into Nurse Station 1. There was an ice chest behind the counter of the nurse station. Resident 4 opened the ice chest and reached his hand in and picked up items and then set them back into the ice chest. Multiple Staff intervened. They distracted and redirected Resident 4 then they gave him a sandwich from the ice chest. Staff did not clean or disinfected the ice chest. None of the food items Resident 4 touched were removed from the ice chest. Resident 4 ran his hands against two med carts then wheeled on. There was no cleaning or disinfection done to any of the surfaces Resident 4 touched. During an observation, on 5/27/20, at 3:43 p.m., the plastic medication cups on medication cart were still in use. During an interview, on 5/27/20, at 3:45 p.m., Staff H stated worked for over a year at the facility. Staff H confirmed the medication administration cart was parked against wall by Nurse Station 1. Staff H stated there was no medication cart stored on the quarantine area. Staff H stated the medication needed for the quarantine area was in West 3's medication administration cart. Staff H Confirmed the medication cart traveled in and out of the quarantine area. Staff H was not aware of any changes to medication administration or cleaning due to the COVID-19 pandemic. Staff H confirmed the entire facility was required to wear a mask. Staff H stated there was no additional PPE required when working in the quarantine area. Staff H was wearing a surgical mask not effective againt COVID-19 particles. During an observation, on 5/27/20, at 3:50 p.m., a container of (brand) cleaning and disinfecting wipes were at Nurse Station 1. The label indicated a three minute wet time to ensure items were clean and disinfected. During a concurrent observation and interview, on 5/27/20, at 3:56 p.m., Resident 1 was in his wheelchair on the East Hall. Staff J was pushing the wheelchair down a corridor towards the lobby. Staff J stated Resident 1 was new to the facility. Staff J stated Resident 1 had episodes of increased confusion. Staff J stated when Resident 1 was confused he would forget his limitations. Staff J stated Resident 1 would try to stand up and walk and then fall. Staff J stated Resident 1 only spoke Hindi. StaffJ stated he was the only staff member that spoke Hindi so when he had time, he would push Resident 1 in the wheelchair and chat with him in Hindi. StaffJ confirmed he was aware Resident 1's room was in the quarantine area. StaffJ was not aware of any change in facility procedures for newly admitted residents. StaffJ stated he had not notified his interactions with the residents on the quarantine unit from his interactions with residents throughout the facility. StaffJ stated he was not provided any specific instructions regarding his interaction with Resident 1. StaffJ confirmed he had not received training on PPE or contact precautions while interacting with residents in the quarantine area. During an observation on 5/27/20, at 4 p.m., Resident 5 was transferred from the quarantine area to a room in West Hall. During a concurrent observation and interview, on 5/27/20, at 4:02 p.m., in the West Hall, with the administrator he confirmed Resident 5 was transferred out of the quarantine area to the West Hall. The administrator stated facility procedure for newly admitted residents included monitoring the time admitted , monitoring for symptoms of COVID-19 and facility needs. The administrator stated the facility could choose to move a resident as they see fit. The administrator confirmed Resident 5 spent five days in quarantine from his date of admission to his transfer date. He stated the reason for moving Resident 5 was the facility needed a bed in the quarantine area for a potential admission. During a concurrent observation and interview, on 5/27/20, at 4:06 p.m., in the dining room, the Director of Nursing (DON) stated the area was a place for staff to chart and social distance. The DON stated the dining room was set up as a decontamination zone. The DON stated the facility had a policy and procedure for durable medical equipment used on more than one resident. The DON stated staff would get bleach wipes from the medication administration cart. The DON stated staff would clean and disinfect between residents. The DON stated the best practice would be to clean the mechanical lift in the quarantine area and then a second cleaning after the lift was transferred for use or storage in the facility. When asked if using the mechanical lift in the quarantine area and then in the West Hall with no cleaning and disinfection between uses, the DON indicated that did not meet the facility's expectation. During an interview, on 5/27/20, at 4:09 p.m., Staff I stated she had worked at the facility for over a year. Staff I stated she worked on the West Hall often and was familiar with the residents and their care needs. Staff I stated she provided direct care for residents in the quarantine area and on West Hall. Staff I confirmed there were residents in the quarantine area that required (brand) mechanical lift or a standing lift to transfer from in bed to sitting in their chair safely. Staff I stated there was one lift and it was passed to different staff as needed. Staff I confirmed the quarantine area did not have its own equipment. Staff I stated the lifts were stored in central supply when not in use. Staff I stated she was not aware of any additional instruction for handling the mechanical lifts. When asked if lifts were cleaned between uses, Staff I stated the lifts were wiped between uses. Staff I stated she used one or two cleaning disinfection wipes and wiped the entire lift. Staff I stated she was not aware of a time requirement for cleaning the lift, and there was no instruction on when to clean the lift. Staff I stated she was not aware of any changes in the cleaning or handling of the mechanical lifts due to the COVID-19 outbreak. During an observation on 5/27/20, at 4:12 p.m., Staff A entered the quarantine area. Approximately two minutes later Staff A exited the quarantine area and proceeded to walk into the medication storage room. Staff A did not perform hand hygiene after exiting the quarantine area. Staff A did not perform hand hygiene prior to entering the clean area of the medication storage room. During an interview, on 5/27/20, at 4:19 p.m., with the manager of environmental services (ES), she stated all staff in the ES department were required to complete training on the COVID-19 pandemic and changes to the procedures for cleaning and disinfection. The ES manager stated they were trained to treat all newly admitted residents as if they could have COVID-19. The ES manager stated they were trained on PPE usage. The ES manager stated the staff wore masks and gloves. The ES manager stated the facility had not requested PPE carts to be set up in the resident areas because there were no confirmed cases of COVID-19 in the facility. The ES manager was asked what the result would be if staff passed through the plastic panel from the quarantine area and grabbed something off the blue linen cart on West Hall and then went back into the quarantine area without performing hand hygiene. The ES manager stated everything touched would be contaminated. She confirmed the blue linen cart would be considered contaminated and taken off the hall to be cleaned and disinfected. During a concurrent observation and interview, on 5/27/20, at 4:33 p.m., in the hallway in front of the dining room. The ES manager was cleaning the (brand)

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) mechanical lift. Start time was 4:23 p.m. and 8 seconds. She stopped wiping at 4:23 p.m. and 59 seconds. The total wiped time was 51 seconds. The ES manager pushed lift into dining room. The ES manager exited the dining room and performed hand hygiene. In another room. At 4:24 p.m. The ES manager stated she probably wiped the lift for about 30 seconds. When how long it was wet for, she stated the lift was still wet. One white piece of paper was used to place on the different sections of the (brand) mechanical lift to check if the equipment was still wet. Of the four surfaces checked only one had any indication of still being wet. The ES manager stated the wipes were not something she used often. She stated she was not aware there was a three minute wet time or what that meant. After reviewing the label the ES manager confirmed the (brand) mechanical lift was not cleaned or disinfected. During an interview, on 5/27/20, at 4:35 p.m., with the DSD, she confirmed a concurrent observation time from 3 p.m. to 3:40 p.m The DSD stated she was the facility's Infection Preventionist. The DSD stated the observations made did not meet the facility's expectations. The DSD confirmed potential contamination and spread of infection for the entire building. The DSD had no answer for why contact precautions were not initiated for new admits other than they test negative at hospital. The DSD confirmed the newly admitted residents had been transferred out of the quarantine area prior to 14 days. The DSD confirmed Resident 5 had only been in the facility 5 days. The DSD stated she would refer to a corporate policy. The DSD could not provide policies regarding the setup and use of the quarantine area. The DSD stated the mattress in the hallway was a potential risk for contamination. The DSD stated the hand hygiene and cleaning of medical equipment observations did not follow the facility's policies. The DSD could not describe how the facility's current use of the quarantine area was preventing COVID-19 from entering and spreading throughout the facility. During an interview, on 5/27/20, at 5 p.m., with the DSD, she explained the proper cleaning and disinfection procedure for the medical equipment. For the (brand) mechanical lift, the DSD stated the facility expectation. After review, the DSD stated it would take at least 5 clothes to cover the surface of the lift. The DSD stated the expectation was to follow the container for the number of minutes for wet time. The DSD confirmed if the object was not wet for the minutes on container it was not disinfected. During an interview, on 5/27/20, at 5:38 p.m., with the administrator the DON and the DSD a request was made for facility policies and procedures. Policies to show the admission process, the cohorting process, the infection control procedures and how those had been modified to prepare for COVID-19. In addition to the policies requested from the DSD which included; cleaning of medical equipment, cleaning shared medical equipment and cleaning anything when it moved from the quarantine side to the rest of the facility. During an interview, on 5/29/20, at 5 p.m., the administrator stated he had reviewed the request for policies and would provide what he had. The administrator stated the admissions process was based on the discretion of himself and the DON. The administrator stated there was no admissions screening policy. The administrator stated the facility tried to place all newly admitted residents into the quarantine area. The administrator stated ultimately placement was based of facility need. The administrator stated the facility did not have a policy or procedure regarding the time a resident stayed on quarantine. The administrator stated if the resident had no signs or symptoms of COVID-19 that resident would be moved into a more permanent room and free up a room in the quarantine area. The administrator stated the decision to move someone was based on facility need. The administrator stated the facility did not have a policy or procedure that explained how the quarantine area would be set up, what the required equipment, staff, and supplies would be needed. The administrator stated the quarantine area was for observation. He stated there was no difference between the rest of the facility and the quarantine/observation area. The administrator confirmed the facility expectation was for standard precautions, with no requirement to designate separate staff or equipment. The administrator stated these decisions were made based on facility need. The administrator stated that unit would be converted to a COVID-19 area if there was an outbreak, if residents were showing symptoms of COVID-19, or it was determined a resident had COVID-19 via lab test. The Administrator provided one policy and stated that was the entirety of the facility's policies for this topic. During the exit conference, on 6/2/20, at 4 p.m., the administrator confirmed there were no other facility policies or procedures regarding admissions during the COVID-19 pandemic, environmental cleaning, or use of PPE. During a review of the facility's policy and procedure titled, Handwashing/ Hand Hygiene, 8/2019, the policy indicated, all personnel shall follow the hand washing procedures to help prevent the spread of infection to other personnel, residents and visitors. The policy indicated 20 instances where hand hygiene was required. During a review of the facility's policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, 10/2018, the policy indicated, reusable resident care equipment will be decontaminated/disinfected between residents. During a review of the Center for Disease Controls (CDC) guidance titled, Responding to Coronavirus (COVID-19) in Nursing Homes, dated 4/30/20, indicated all facilities should adhere to current CDC infection prevention and control recommendations, including universal source control measures. The Considerations for new admissions or readmissions to the facility section indicated facilities should create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options included placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. The section further indicated all recommended COVID-19 PPE should be worn during care of residents under observation, which included use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. The section further indicated a single negative test upon admission did not mean that the resident was not exposed or would not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. The section indicated new residents could be transferred out of the observation area or from a single to a multi-resident room if they remained afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). During a review of the California Department of Public Health All Facilities Letter titled, Preparing for COVID-19 in California Skilled Nursing Facilities, dated 4/20/20 indicated, The California Department of Health (CDPH) strongly recommends skilled nursing facilities (SNF) prepare for novel coronavirus disease (COVID-19). Elderly persons and those with chronic medical conditions may be at higher risk for severe illness and death from COVID-19. All California SNFs should take steps to: 1) Prevent introduction of COVID-19 into their facility 2) Detect COVID-19 in their facility 3) Prepare to receive residents with suspected or confirmed COVID-19 infection 4) Prepare to care for residents with suspected or confirmed COVID-19 infection 5) Prevent spread of COVID-19 within their facility The prevent introduction section indicated: Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19. All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic [DIAGNOSES REDACTED]-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE.