STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555276	A. BUILDING _____ B. WING _____	**04/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN BRUNO SKILLED NURSING	**890 EL CAMINO REAL SAN BRUNO, CA 94066**

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 -** Many	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review, the facility failed to develop, implement, and maintain an infection prevention and control program to thoroughly track the infections of residents in the building. Additionally, the facility failed to ensure that staff appropriately disposed of potentially contaminated personal protective equipment, after leaving a resident room which housed a presumed postive COVID-19 resident. Findings include: 1. On 4/2/20 at at 9:15am, the Administrator and the Director of Nursing (DON) indicated that the facility housed three residents that were exposed to a COVID-19 positive hospital employee prior to admission to the facility. All three of the residents were exposed between 3/19/20 and 3/25/20, and did not display any signs or symptoms of an acute COVID-19 infection. Two of the residents received testing for COVID-19, and the third resident's physician declined to test. The facility placed all three residents on droplet precautions (a form of medical isolation) following notification from the hospital that the employee was positive for COVID-19 and the residents were exposed. On 4/2/20 at 9:20am, the DON indicated that one of the residents (R2) received the results of his test just a little bit ago, and that the results were negative. R2's physician discontinued his isolation precautions. The DON indicated that the facility continued to await R1's test results. The DON indicated that licensed nursing staff screened the residents received screening at least twice a day for symptoms of COVID-19. On 4/2/20 at 10:15am, an observation revealed that the door to R1's room had signage regarding R1's droplet precautions, what personal protective equipment (PPE) was required to enter the room, and had an isolation storage cart next to the door that held extra PPE. The extra PPE included multiple disposable masks. On 4/2/20 at 10:45am, Licensed Practical Nurse (LPN1) exited R1's room after performing a blood glucose reading for R1's roommate, wearing disposable gloves and a disposable surgical mask. In order to reach the roommate, LPN1 walked directly in front of R1's bed, personal items, and other belongings. After LPN1 left the room, she removed her gloves, performed hand hygiene with alcohol-based hand rub, and cleansed the glucometer (device used to obtain blood sugar readings). LPN1 failed to remove and dispose of her mask. LPN1 then entered another patient's room, wearing the same disposable mask. Observation revealed that numerous clean masks were available in R1's isolation cart, next to her door. On 4/2/20 at 10:50am, LPN1 indicated that because she obtained a blood sugar reading for R1's roommate, she did not have to don all required PPE or dispose of her mask after exiting the room. LPN1 indicated that she was aware that the facility was awaiting R1's COVID-19 test results, and that until proven otherwise, R1 was presumed positive for the disease. LPN1 touched the outside of the mask with her fingers during the interview, then touched other surfaces, including the top of the medication cart and her scrubs. On 4/2/20 at 11:10am, the DON indicated that her expectation of staff would be to dispose of potentially contaminated masks after leaving the rooms of residents on isolation precautions. 2. Review of the facility's infection control logs for February, 2020, indicated nine infections for the month. The log revealed each resident's name, admitted , site of infection, and treatment. The facility failed to document onset dates for three of the infections, failed to document any resolution dates for any of the infections, failed to document if the ordered antibiotic was effective against the infectious organism for all nine infections, and failed to track signs and symptoms of infection for five of the infections. One urinary tract infection included documentation that the infectious organism was extended-spectrum beta lactamase (ESBL), an infection that requires isolation precautions. The log failed to document if isolation precautions were implemented. Review of the facility's infection control logs for March, 2020, failed to indicate that the facility housed three residents that had been exposed to COVID-19, that the residents required isolation precautions, or that facility staff were performing routine screening of the residents. Further review of the infection control log for March, 2020, revealed that the facility logged 12 infections for the month. Of the 12 infections, the facility failed to track signs and symptoms for three infections and failed to track infection resolution dates for all infections. On 4/2/20 at 2:00pm, the DON indicated that the infection control log should have included the three presumed-positive COVID-19 resident's names and other applicable information for tracking purposes. The DON indicated that the facility failed to track resolution dates for the infections because facility staff felt that when a resident finished their course of antibiotics, the infection was resolved. The facility failed to provide a policy for infection control.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE