STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056279	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIERRA VIEW HOMES	1155 E. SPRINGFIELD AVENUE REEDLEY, CA 93654

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 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store medications in locked compartments for eight of eight sampled residents (Resident 1, 2, 3, 4, 5, 6, 8 and 9) cohorted (group of residents who are infected with the same infection) in the [MEDICAL CONDITION] (COVID-19- a contagious serious respiratory infection transmitted from person to person) unit when physician prescribed and over the counter medications were stored in an open utility cart not equipped with drawers or locks. This failure potentially made medications accessible to unauthorized staff and the risk for medications to be lost or misplaced. Findings: During an observation on 7/4/2020 at 11:30 a.m., with Licensed Vocational Nurse (LVN) 3 in the dedicated workroom next to the COVID-19 bed rooms, a metal utility cart not equipped with drawers, locks or doors was located next to LVN 3's laptop. On top of the utility cart were three baskets used to store prescribed medications. One basket had one large tapering strip roll (packaged medication in a roll or strip made up of small daily pouches) of medications. Another basket had one medium tapering strip roll of medication, two-insulin (medication injected for the treatment of [REDACTED]. On a separate utility cart, there were 17 containers with over the counter medications and vitamin supplements. The supplements were Vitamin C, Vitamin D, fiber, aspirin ([MEDICATION NAME]), [MEDICATION NAME] sodium (loosens stools and increase bowel movements), sodium [MEDICATION NAME] (salt supplement), and [MEDICATION NAME] (allergy medication). During an interview on 7/4/2020 at 11:40 a.m., LVN 3 stated the medications on top of the utility carts were temporarily being stored in the baskets. LVN 3 stated the utility carts were the temporary medication carts. LVN 3 stated the temporary medication carts did not come equipped with doors, drawers or locks. LVN 3 stated the utility carts and contents of the utility carts were accessible to anyone who entered the workroom. LVN 3 stated the medications belonged to Residents 1, 2, 3, 4, 5, 6 8 and 9 who were being cohorted in the COVID-19 unit. During an observation on 7/4/2020 at 12:05 p.m., LVN 3 entered the COVID-19 unit and left the utility carts and the medications alone and unattended. During an interview on 7/4/2020 at 12:30 p.m., with the Director of Nursing (DON), the DON stated she thought the medications were being stored in a locked cabinet located under the sink of the workroom. The DON stated the medications needed to be stored in locked compartments. During a review of the facility policy and procedure titled, MEDICATION STORAGE IN THE FACILITY dated 2015, indicated, Medications .are stored safely, securely, and properly, following manufacturers recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures . Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications such as medication aides are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access .
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	**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 infection prevention and control program for the prevention of a [MEDICAL CONDITION] (COVID-19- a contagious serious respiratory infection transmitted from person to person) outbreak for 28 of 57 sampled Residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 22, 23, 24, 25, 26, 27 and 28) when: 1. Dedicated and trained staff were not trained to conduct active COVID-19 screening of Health Care Personnel (HCP) and instead HCP screened themselves for symptoms of COVID-19, prior to the start of all three shifts (morning, evening and night) and potentially placed 57 of 57 residents at risk from symptomatic COVID-19 staff. 2. The Director of Staff Development/Infection Preventionist (DSD/IP) did not provide education to HCP on the most current signs and symptoms of COVID-19 infection. Staff did not know what steps to follow when symptoms developed during their shift. Three of three Certified Nursing Assistants (CNA 12, CNA 13, and CNA 3) provided resident care while experiencing symptoms of COVID-19 (loss of taste, loss of smell and headache) on 6/25/2020 subsequently exposing Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15 16, 17, 18, 19, 20, 21 22, 23, 24, 25, 26, 27 and 28 to COVID-19 infection. 3. The DSD/IP did not implement a facility wide infection control (IC) program to prevent, identify, investigate and control communicable diseases and infections among residents and staff. The DSD/IP failed to conduct education and training of staff to correct and improve IC practices such as the screening process and current signs and symptoms (s/s) of COVID-19 in the facility which subsequently lead to Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, and 15's COVID-19 infection and to the exposure of Residents 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 and 28. 4. CNA 1 took a dedicated thermometer used for the screening of HCP to measure a resident's temperature inside the bedroom without disinfecting the thermometer prior to and after the thermometer's use. Because of the failures to maintain essential and effective IC activities to reduce the spread of a COVID-19 outbreak, and the potential serious harm to Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27 and 28, related to employees working with symptoms associated with COVID-19 and eventually laboratory tested as COVID-19 positive, an Immediate Jeopardy situation (IJ) was called on 7/3/2020 at 7:05 p.m., under Code of Federal Regulations (CFR) 483.80 (F880-Infection Prevention and Control) with the facility Administrator (ADM) and Director of Nursing (DON). The facility submitted a Plan of Removal to address the IJ situation, which included having a designated trained screener for each shift to actively screen all HCP prior to the start of each shift; in-service training was provided to all staff on the signs and symptoms (s/s) of COVID 19 when to report and to whom to report; with a plan to provide in-services on an ongoing basis on s/s of COVID-19; a full time IP to implement monitoring and surveillance to track COVID-19 and staff compliance to infection control practices. The Plan of Removal was accepted on 7/5/2020 at 4:33 p.m. While onsite, the surveyors verified and confirmed the interventions to address the IJ situation on the Plan of Removal were fully implemented. The IJ was removed on 7/7/2020 at 2 p.m., with the ADM and DON. The severity of the violation remains at a scope and severity of an 'L'. Findings: 1. During an observation on 7/3/2020 with the ADM, at 7:23 a.m., at the south entrance of the facility, a screening station was located on the right side of the hallway. There was no staff available to screen employees or visitors who entered the facility. The ADM called staff to the facility entrance to screen the two nurse evaluators. The DON approached the unattended entrance screening station, and stated her hands were soiled with residue from a broken fish tank and was unable to complete the COVID-19 screening. The DON called on an available staff member to conduct the screening of the two nurse evaluators. During a concurrent observation and interview on 7/3/2020, at 7:27 a.m., with Certified Nursing Assistant (CNA 1) at the screening station, CNA 1 stopped the distribution of meal trays from nearby resident rooms. CNA 1 approached the screening station, and proceeded to conduct the screening of the two nurse evaluators. CNA 1 measured the tympanic (ear) temperature and asked the screening questions from

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) a written questionnaire. CNA 1 documented the information collected on the screening data form. CNA 1 stated the screening station was not staffed routinely. CNA 1 stated if staff needed to be screened the staff would call out for an available staff member to stop what they were doing and request they come and perform the temperature screen. CNA 1 completed the COVID-19 screen on the two evaluator nurses proceeded to the south hallway to continue picking up trays from Resident rooms. During a review of the undated and untitled screening data form used to collect the screening information, the questionnaire contained seven columns. The first column indicated the date the screening was conducted, the second column indicated, Employee or HCP's Name or ESSENTIAL VISITOR. The third column indicated, Department. The fourth column indicated, TEMP LESS THAN 100.4? The fifth column indicated, DO YOU HAVE A COUGH, SORE THROAT OR SHORTNESS OF BREATH? the sixth column indicated, In the last 14 days have you been in contact with symptoms of COVID-19 or tested positive? (IF YES, ask for a nurse before entry). The seventh column indicated, Wash your hands or do hand hygiene! During an interview on 7/3/2020 at 7:35 a.m., with the DON, the DON stated Residents 1, 2, 3, 4, 5 and 6 were positive for COVID-19. During a review of Resident 1's laboratory COVID-19 result dated 7/2/2020, indicated Resident 1 tested positive for COVID 19 on 7/2/2020. During a review of Resident 2's laboratory COVID-19 result dated 6/28/2020, indicated Resident 2 tested positive for COVID 19 on 6/28/2020. During a review of Resident 3's laboratory COVID-19 result dated 7/2/2020, indicated Resident 3 tested positive for COVID 19 on 7/2/2020. During a review of Resident 4's laboratory COVID-19 result dated 6/27/2020, indicated Resident 4 tested positive for COVID 19 on 6/27/2020. During a review of Resident 5's laboratory COVID-19 result dated 6/27/2020, indicated Resident 5 tested positive for COVID 19 on 6/27/2020. During a review of Resident 6's laboratory COVID-19 result dated 7/2/2020, indicated Resident 6 tested positive for COVID 19 on 7/2/2020. During an interview on 7/3/2020, at 7:55 a.m., with CNA 1, CNA 1 stated the facility did not have dedicated staff to screen the staff or visitors entering the facility. CNA 1 stated when she entered the facility and a staff member was not available to conduct the screen she would proceed to screen herself. CNA 1 stated she completed the screening questionnaire, took her own temperature and documented the results on the screening log. CNA 1 stated she had been performing her own screening for two months. During an interview on 7/3/2020, at 8:05 a.m., with CNA 2, CNA 2 stated, she started her shift the morning of 7/3/2020 at 6 a.m. CNA 2 stated there was no staff assigned to conduct and complete the screening at the beginning of her shift. CNA 2 stated, I have been doing my own screening since June. CNA 2 stated she did not receive training on the screening process or the steps that needed to be completed prior to entering the facility. During an interview on 7/3/2020, at 8:06 a.m., with CNA 9, CNA 9 stated there was no dedicated or designated staff to conduct the screening of COVID-19 s/s prior to the start of each shift. CNA 9 stated she and another CNA checked their temperatures prior to the start of the shift on 7/3/2020. CNA 9 stated the DSD previously told her it was ok for them to conduct their own screening of COVID-19 symptoms. During an interview on 7/3/2020, at 8:15 a.m., with CNA 10, CNA 10 stated after clocking in that morning (7/3/2020) she took her own temperature and answered the screening questionnaire by herself because no one was at the screening station. During an interview on 7/3/2020, at 10:05 a.m., with Licensed Vocational Nurse (LVN 1), LVN 1 stated she started her shift that morning (7/3/2020) at 6 a.m. LVN 1 stated there was no dedicated or designated staff to conduct the screening of COVID-19 s/s prior to the start of each shift. LVN 1 stated she had been performing her own COVID-19 screen each time she arrived for work for the past three months. LVN 1 stated she had not observed staff at the screening station conducting active COVID-19 screening. LVN 1 stated she did not feel comfortable screening herself, but had not addressed her concern with anyone in the facility administrative or nursing staff. During an interview on 7/3/2020, at 10:25 a.m., with Housekeeping Supervisor (HS), the HS stated there was no dedicated or designated staff to conduct the COVID -19 screening. The HS stated she screened herself in the morning, prior to the start of her shift on 7/3/2020. The HS stated, I do my own screening most of the days (and have done so) for the last three months. During an interview on 7/3/2020, at 10:29 a.m., with LVN 5, LVN 5 stated there was no dedicated or designated staff to conduct the COVID -19 screening that morning on 7/3/2020. During an interview on 7/3/2020, at 12:05 p.m., with CNA 11, CNA 11 stated, she screened herself prior to the start of her shift and had been performing her COVID-19 self-screening independently for the past month. CNA 11 stated she was concerned staff were screening themselves independently without oversite and could erroneously document the self-screening. During an interview on 7/3/2020, at 1:20 p.m., with DSD/IP, the DSD/IP stated the facility was required to conduct active screening of all HCP and visitors who entered the facility. The DSD/IP stated the facility staff needed to have one person screen the other. The DSD/IP stated she did not have enough staff to assign as designated screeners. The DSD/IP stated local public health workers visited the facility on 7/2/2020 and instructed her to have dedicated staff for the completion of screening HCP and visitors. The DSD/IP stated she had not yet implemented the instructions. DSD/IP stated the residents in the facility were at risk to contract COVID-19 if active screening of staff was not conducted. DSD/IP stated, The point of entry is a vulnerable area for infectious diseases to come into the facility unchecked, and placed staff and residents at risk. The DSD/IP was asked about the systems the facility implemented for infection control and did not answer. During an observation on 7/3/2020, at 2:23 p.m., at the screening station, CNA 8 was standing at the screening station using an ear thermometer and took his own temperature. CNA 8 documented the results on the screening data form. During an interview on 7/3/2020, at 4:12 p.m., with CNA 8, CNA 8 stated he had been screening himself for the past three months. CNA 8 stated the screening area did not have a designated staff to conduct the screening. During an interview on 7/4/2020, at 10:45 a.m., with the DON, the DON stated the COVID-19 unit had one point of entry and exit. The DON stated a screening station was in place for the staff to use. During an observation on 7/4/2020, at 10:50 a.m., in the COVID-19 unit, a screening area for staff and visitors was not set up at the side entrance of the facility. During an interview on 7/4/2020, at 11:01 a.m., with LVN 3, LVN 3 stated, clear directions were not provided on the screening process for all staff entering the COVID-19 unit. LVN 3 stated another nurse took her temperature early in the morning on 7/4/2020 although the questionnaire for COVID-19 screening was not completed. LVN 3 stated she was not actively screened since 6/28/2020, when she was initially assigned to the COVID-19 unit. LVN 3 stated active screening should have been completed and documented upon entering the facility. LVN 3 stated there were two additional COVID positive residents identified on the evening of 7/3/2020 and stated Resident 8 and Resident 9 were moved into the COVID-19 unit. During a review of Resident 8's COVID-19 laboratory report dated 7/3/2020, indicated Resident 8 was positive for COVID 19 on 7/3/2020. During a review of Resident 9's COVID-19 laboratory result dated 7/3/2020, indicated Resident 9 tested positive for COVID 19 on 7/3/2020. During an interview on 7/4/2020, at 11:30 a.m., with CNA 5, CNA 5 stated she was assigned to work in the COVID -19 unit since 6/28/2020. CNA 5 stated the COVID-19 unit had a separate entrance. CNA 5 stated she was not screened prior to entering the COVID-19 unit since 6/28/2020. CNA 5 stated, We just check our temperatures throughout the shift but do not document our temperatures. During an interview on 7/6/2020, at 11:15 a.m., with the ADM, the ADM stated there were seven additional residents identified positive for COVID-19 on 7/6/2020. The ADM stated the positive COVID-19 results were on Resident 7, 10, 11, 12, 13, 14 and 15 which brought the total to 15 positive cases in the residents of the facility. During a review of Resident 7's COVID-19 laboratory report dated 7/5/2020, indicated Resident 7 was positive for COVID 19 on 7/5/2020. During a review of Resident 10's COVID-19 laboratory report dated 7/5/2020, indicated Resident 10 was positive for COVID 19 on 7/5/2020. During a review of Resident 11's COVID-19 laboratory result dated 7/5/2020, indicated Resident 11 tested positive for COVID 19 on 7/5/2020. During a review of Resident 12's COVID-19 laboratory result dated 7/5/2020, indicated Resident 12 tested positive for COVID 19 on 7/5/2020. During a review of Resident 13's COVID-19 laboratory result dated 7/5/2020, indicated Resident 13 tested positive for COVID 19 on 7/5/2020. During a review of Resident 14's COVID-19 laboratory report dated 7/5/2020, indicated Resident 14 was positive for COVID 19 on 7/5/2020. During a review of Resident 15's COVID-19 laboratory result dated 7/5/2020, indicated Resident 15 tested positive for COVID 19 on 7/5/2020. During a review of the facility's policy and procedure titled, (Employee/Visitor Screening during COVID-19), dated 3/20/2020, indicated Policy: .To protect residents from harmful pathogens .identifying persons with symptoms before they enter the facility . Procedure: .all who enter the facility are screened before entering .individuals are screened .before being allowed to enter the facility . During a professional reference review retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html on 7/17/2020, titled, Preparing for COVID-19 in Nursing Homes dated 6/25/2020 indicated, Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. .Actively take their temperature* and document absence of symptoms consistent with COVID-19. Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.*Fever is either measured temperature (greater than) 100.0 (degrees) F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed (weak immune system), or taking certain medications (e.g., NSAIDs) . 2 a. During an

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) interview on 7/3/2020, at 8:05 a.m., with CNA 2, CNA 2 stated CNA 2 stated she believed a temperature of 101 degree Fahrenheit or higher needed to be reported to the DON. CNA 2 stated the DSD/IP told her (an employee) with a temperature of 101 degree Fahrenheit or above needed to be reported to a nurse. CNA 2 stated that the most current s/s of COVID-19 were not provided. During an interview on 7/3/2020, at 8:15 a.m., with CNA 10, CNA 10 stated having a temperature greater than 99 degrees F was unacceptable and would need to alert a nurse. CNA 10 stated if during her shift she felt s/s of COVID-19, she would alert the nurse in charge. CNA 10 was asked to verbalize reportable s/s of COVID-19. CNA 10 stated she would report cough, fever and shortness of breath; and was unaware of the additional symptoms. During a telephone interview on 7/3/2020, at 9:57 a.m., with CNA 12, CNA 12 stated she worked on 6/25/2020 during the PM shift from 2:15 p.m., to 10:45 p.m. CNA 12 stated she completed the COVID-19 HCP screening process independently that day (6/25/2020) because there was no staff available to conduct active screening. CNA 12 stated the main reportable s/s of COVID-19 were high fever and SOB. CNA 12 stated on 6/25/2020 during her lunch break she experienced the loss of taste and smell. CNA 12 stated she did not know the loss of taste and smell were s/s of COVID-19, and continued to provide resident care after her lunch break. CNA 12 stated she did not receive an updated in service to let her know the loss of taste and smell were s/s of COVID-19. CNA 12 stated she tested positive for COVID-19 on 6/27/2020. During a concurrent interview and record review on 7/3/2020, at 5:12 p.m., with Medical Records (MR), MR reviewed CNA 12's written Work Schedule for 6/24/2020 and 6/25/2020. MR stated CNA 12 worked on 6/24/2020 during the PM shift (2:15 p.m. to 10:45) and provided care to Residents 1, 3, 6, 7, 9, 13, 14. MR stated on 6/25/2020, CNA 12 provided care to Residents 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. During a concurrent interview and record review on 7/3/2020, at 5:40 p.m., with the DON, the DON reviewed the facility's CNA electronic assignment titled, Point of Care History Report and stated CNA 12 was also assigned to Residents 2 and 4 on 6/24/2020, one day prior to exhibiting symptoms of COVID-19. During a review of the facility document titled, Payroll report with specific Dates dated 6/25-6/26 indicated, CNA 12 worked on 6/25/2020 from 2:19 p.m., through 10:34 p.m. During a review of the facility document titled, REPORT OF POSITIVES AT (Skilled Nursing Facility) undated indicated, CNA 12 tested positive for COVID-19 on 6/28/2020. 2 b. During a telephone interview on 7/3/2020, at 3:41 p.m., with CNA 13, CNA 13 stated she worked on 6/25/2020 during the PM shift from 2:15 p.m., to 10:45 p.m. CNA 13 stated she completed the COVID-19 self-screening symptom questionnaire for the past month prior to the start of her shift. CNA 13 stated on 6/25/2020 during her lunch break she experienced the loss of taste and smell. CNA 13 stated she was not in-serviced for all the s/s of COVID-19 and was unaware the loss of taste and smell were s/s of COVID-19. CNA 13 stated she was experiencing symptoms of the common cold. CNA 13 stated the only symptoms she was aware of for COVID-19 were high fever, cough and sore throat. CNA 13 stated, she continued to provide Resident care unaware she was experiencing s/s during her lunch break. CNA 13 stated she tested positive for COVID-19 on 6/27/2020. During a concurrent interview and record review on 7/3/2020, at 5:13 p.m., with Medical Records (MR), MR reviewed CNA 13's Work Schedule for 6/25/2020. MR stated CNA 13 worked on 6/25/2020 PM shift (2:15 p.m. to 10:45) and provided care to Residents 11, 12 and 15. During a review of the facility document titled, Payroll report with specific Dates dated 6/25-6/26 indicated, CNA 13 worked on 6/25/2020 from 2:22 p.m. through 10:46 p.m. During a review of the facility document titled, REPORT OF POSITIVES AT (Skilled Nursing Facility) undated indicated, CNA 13 tested positive for COVID-19 on 6/27/2020. 2 c. During a telephone interview on 7/3/2020, at 4:55 p.m., with CNA 3, CNA 3 stated, the last day she worked at the facility was on 6/25/2020 on the PM shift. CNA 3 stated she started her shift at 2:15 p.m., and ended it at 10:45 p.m. CNA 3 stated she had a headache during the shift and did not think anything of it. CNA 3 stated she continued to provide resident care unaware the headache was a symptom of COVID-19 and worked throughout her shift. CNA 3 stated she tested positive for COVID-19 on 6/28/2020. During a concurrent interview and record review on 7/3/2020, at 5:13 p.m., with Medical Records (MR), MR reviewed CNA 3's Work Schedule from 6/24/2020 and 6/25/2020. MR stated CNA 3 worked on 6/24/2020 during the PM shift (2:15 p.m. to 10:45) and provided care to Residents 11, 12 and 15. MR stated CNA 3 worked with CNA 12 on 6/25/2020 during the PM shift and helped care for Residents 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, and 28. During a review of the facility document titled, Payroll report with specific Dates dated 6/25-6/26, indicated, CNA 3 worked on 6/25/2020 from 2:19 p.m., to 10:35 p.m. During a review of the facility policy and procedure titled Coronavirus Preparation Response, and Mitigation dated 5/27/2020, indicated, Policy: .It is our policy that we will make efforts to protect our residents in our facility from these diseases . Healthcare Personnel training a. Staff will be trained to recognize signs and symptoms of COVID-19. During a professional reference review retrieved from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html on 7/17/2020, titled, Symptoms of Coronavirus dated 6/25/2020 indicated, Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea. 3. During an interview on 7/3/2020, at 1:20 p.m., with the DSD/IP, IP stated, she did not have documentation and did not have lesson plans on COVID-19 for staff training. The DSD/IP stated she did not provide in-service training for the screening process. The DSD/IP did not answer when asked if the facility IC committee completed a risk assessment in relation to infection control and COVID-19. The DSD/IP was asked to share the systems the facility had in place to track and conduct surveillance., the DSD/IP stated she did not have time to complete the logs and spreadsheets (a system of identifying all residents and staff on one monitoring tool called a line-list, (The line list serves as surveillance tool to track and monitor the clinical and COVID-19 status of each resident and staff member)) asked of her. During a professional reference review retrieved from https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf on 7/20/2020, titled, Long-Term Care (LTC) Respiratory Surveillance Line List dated 3/12/2019 indicated, The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a nursing home or other LTC facility. Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness . Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring . During an interview on 7/3/2020, at 5:47 p.m., with the DSD/IP, the DSD/IP stated she was overburdened with duties of which involved staff development and did not have sufficient time to complete IC duties. The DSD/IP stated she did not have documentation that she had updated anything. The DSD/IP stated the ADM was aware she was overloaded with the duties of DSD and IP. The DSD/IP stated she was informed the ADM and DON that she was busy completing DSD duties and was not fulfilling IP duties. The DSD/IP could not recall the date she communicated to the ADM and DON that her DSD duties were affecting the IP duties. The DSD/IP stated she did not provide the staff up to date in-service education about the most current s/s of COVID-19. The DSD/IP stated the facility staff did not know what s/s needed to be reported other than cough, fever and SOB. The DSD/IP stated the infection surveillance was not updated and she did not have an effective tracking system to record outbreaks. The DSD/IP stated she did not have the time she needed to complete all of her tasks. The DSD/IP stated the last in-service education she provided to all of the facility staff was in March 2020 when the pandemic was initially declared. The DSD/IP stated she did not provide any additional in-service education on infection control since March 2020. The DSD/IP stated she was unaware who oversaw her work and felt the administrative staff should have known that she was overloaded with duties in the IP and DSD department. During a concurrent interview and record review on 7/3/2020, at 6:15 p.m., with DSD/IP, the DSD/IP reviewed the in-service binder and stated the last in-service conducted was on 3/17/2020. The DSD/IP stated there were no additional in-services related to infection control in the in-service education binder. During an interview on 7/3/2020, at 6:14 p.m., with DON, the DON stated the facility had no issues in the infection control department. The DON stated the DSD/IP was able to perform her duties and was not having a difficult time conducting and performing her duties. The DON stated that she was running a good facility and her facility was not the only facility experiencing an outbreak of COVID-19. The DON was unable to describe and explain the level of oversite she offered the DSD/IP. The DON stated there were times when nurses who were not IC certified and nurses who were not DSD certified had come to help the DSD/IP. The DON stated they did not feel it was necessary to have a dedicated staff assigned to conduct screening of HCP and visitors. The DON stated she felt the staff could perform their own screening. During a review of the facility's policy and procedure titled, (Director of Staff Development Job Description), (undated), indicated, .trains, develops plans, directs, and coordinates programs to enhance the knowledge skills of the staff .will review and evaluate training and apprenticeship programs for compliance with government standards .Essential functions . Establish/implement training program .train staff for best practices .compliance with state and federal requirements .Coordinate, develop and implement employee education .Ensure education policy procedures meet regulation standard .Organize facility wide in-service .will be responsible for functions of the employee training and education. During a review of the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056279	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIERRA VIEW HOMES	**1155 E. SPRINGFIELD AVENUE REEDLEY, CA 93654**

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 -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) policy and procedure titled, (Infection Prevention IP Nurse Job Description) (undated), indicated, .specializes in preventing the spread of infectious agents, such as viruses and bacteria . training on how to prevent contamination .organize infection prevention in-services . 4. During an observation on 7/3/2020, at 9:11 a.m., CNA 1 picked up the tympanic thermometer from the screening station located at the entrance of the facility. CNA 1 took the thermometer into a resident's room and measured the temperature of the resident inside the room without disinfecting the thermometer. CNA 1 exited the room and placed the thermometer back onto the screening table without disinfecting the thermometer. During an interview on 7/3/2020, at 9:17 a.m., with CNA 1, CNA 1 stated she did not have a thermometer nearby so she decided to use the screening thermometer. CNA 1 stated she should have disinfected the thermometer after use to prevent cross contamination but did not do so. During an interview on 7/3/2020, at 5:57 p.m., IP stated, any device including thermometer should have been disinfected after use to prevent the transmission of infections. During a review of the facility policy and procedure titled Disinfecting Shared Equipment dated 3/2020, indicated, Pathogens can be transmitted through the use of equipment that is shared between residents and/or employees. It is important for the protection of residents and staff that this route of transmission be prevented . When equipment such as thermometers and blood pressure cuffs are used, they must be cleaned and then disinfected with a disinfectant that will effectively kill pathogens that may be transmitted between people. This will be done by the staff member that is utilizing it before using it on the next person .