STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055288	A. BUILDING _____ B. WING _____	03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SONOMA POST ACUTE	570 2ND STREET WEST SONOMA, CA 95476

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a COVID-19 FOCUSED SURVEY FOR INFECTION CONTROL. A Covid-19 Focused Infection Control Survey was conducted by the California Department of Public Health on behalf of the Centers for Medicare and Medicaid Services (CMS) on 3/1/2022. The facility was found to be not in compliance with 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for Covid-19. Total Residents: 77 Representing the California Department of Public Health: Surveyor 40849, Health Facilities Evaluator Nurse (HFEN). Deficiencies were identified.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(a): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880	1) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident number 1 was admitted to Sonoma Post Acute after the resident finished his isolation in the hospital and was asymptomatic. 2) How the facility will identify other residents having the potential to be affected All residents by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected of the deficiency if staff break Infection control protocols required for red, yellow and green zones and will be identified via clinical review by Director of Nursing and Infection Preventionist.	3/30/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/29/22

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.

POC accepted 4-6-22 at 1:50pm and Jon Olson, NHA notified by phone. GBlake-Carberry, RN/HFES

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F 880	Continued From page 1 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recure; In-servce Training was immediately provided to Licensed nurses, Certified Nursing Assistants, and therapist on 3/3/2022 on proper COVID19 infection prevention and control measures specific to: a) Cohorting residents- Red Zone, Yellow Zone and Green Zone b) Appropriate PPE to be worn in rooms with Transmission-based precaution c) Visitor screening including process to provide information on facility process for ensuring visitors are informed on action to take in case they develop signs and symptoms of Covid-19 after visiting the facility. Return Demonstration on handwashing and donning and doffing of Personal Protective Equipment was done on 3/11/2022 to 3/14/2022 by the Infection Preventionist and Director of Staff and Development and on proper COVID19 infection prevention and control measures protocol. Director of Nursing or Infection Preventionist will be responsible for designating red, yellow and green zones through review of clinical review and residents co-horting. Signs and symptoms of COVID and actions to take if symptoms present after visiting facility will be posted at front door and at the entrance desk. Screening log has been updated to include education on COVID symptoms and actions to take if present after facility visit.	

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F 880	Continued From page 2 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement infection prevention and control practices when: 1. One Covid-19 (respiratory disease caused by SARS-CoV-2 and spread from person to person) positive resident (Resident 1) was cohorted with non-Covid-19 residents (Resident 2, 3 and 4). 2. Three staff did not wear proper PPE (personal protective equipment-gown, gloves, N95 respirator, face shield/goggles) inside the yellow zone (area for residents under observation for signs and symptoms of Covid-19) room. 3. Facility did not inform visitors to monitor for signs and symptoms of Covid-19 and actions to take if signs and symptoms occur. These failures could have resulted in the spread of Covid-19 infection among residents, staff, and visitors in the facility. Findings: 1. During an observation on 3/1/22, at 9:17 a.m., one room was observed with signage that read, "STOP YELLOW ZONE."	F 880	4) How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system Director of Nursing or Infection Preventionist will monitor all new admissions coming in the facility and will identify room assignments to ensure red, green, and yellow zones are correctly assigned. Proper transmission based protocol will be initiated if needed. Director of Nursing or Infection Preventionist will monitor correct use of Personal Protective Equipment using the CDPH form three times weekly for 60 days. Administrator, front desk, or social service director will monitor visitor screening process including education to family members related to proper action to take if they exhibit signs or symptoms of COVID. Administrator, Director of Nursing, or Infection Preventionist will ensure proper reporting of Covid 19 positive residents and staff. Monitoring results will be brought to QAPI (Quality Assurance Process Improvement) Committee for review and recommendations. 5) Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. 3/30/2022	3/30/22

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F 880	Continued From page 3 During an interview on 3/1/22, at 10:11 a.m., Licensed Staff D was asked about residents in the yellow zone room. Licensed Staff D stated residents in the yellow zone room were new admits and three of them were unvaccinated (Resident 2, 3 and 4), and one resident (Resident 1) was fully vaccinated and tested positive for Covid-19 upon admission. Licensed Staff D stated the facility received a report on admission that Resident 1 tested negative after isolation in the red zone in another facility. Licensed Staff D further stated that upon admission, Resident 1 was tested for Covid-19 and was positive and was cohorted to other newly admitted unvaccinated residents who tested negative for Covid-19. Licensed Staff D was asked about the facility process if a resident tested positive for Covid-19. Licensed Staff D stated, symptomatic Covid-19 positive resident should be in the Covid unit (Red Zone) and the asymptomatic Covid-19 positive resident should be in the yellow zone. Licensed Staff D was asked if they re-tested Resident 1 for Covid-19 and he stated, "not yet." During an interview on 3/1/22, at 11:43 a.m., Licensed Staff D was asked about facility process in reporting Covid-19 positive residents and staff, and he stated they would notify the County (Local Health Department-LHD) of positive results. Licensed Staff D further stated, the facility did not notify the County for Resident 1's Covid-19 positive test result because he and Management Staff E decided there was no need to notify the County. During an interview on 3/1/22, at 12:57 p.m., Management Staff F and Licensed Staff D were asked for the list of Covid-19 positive residents in	F 880		

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F 880	Continued From page 4 the last four weeks, and they both stated they did not have a list of Covid-19 positive residents in the facility. Licensed Staff D was asked about Resident 1's test result and he stated "yes" and provided the copy of the Covid-19 positive test result. During an interview on 3/1/22, at 2:47 p.m., Management Staff E was asked about facility process in Covid-19 testing and cohorting. Management Staff E stated the facility did not test new admit residents who finished isolation in another facility, and they did not accept Covid-19 positive residents. Management Staff F stated that Resident 1's Covid-19 positive test result was not an issue, and he was asymptomatic, and the testing was an "accident." Management Staff D further stated, they did not notify the County for Resident 1's Covid-19 positive result, the hospital (where Resident 1 was discharged from) "should have" reported it to the County. 2. During an observation on 3/1/22, at 9:17 a.m., one room was observed with signage that read, "STOP YELLOW ZONE WEAR GOWN, FACE SHIELD/GOGGLES, N-95 MASK AND GLOVES." There was a PPE cart with signage and picture for PPE use outside the room. During an observation on 3/1/22, at 9:17 a.m., Unlicensed Staff A was observed without PPE except for a regular black mask, inside the yellow zone room. During an observation on 3/1/22, at 9:21 a.m. and at 9:33 a.m., Licensed Staff B was observed coming out from behind the privacy curtain of Resident 1 without PPE, except for a regular surgical mask.	F 880		

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F 880	Continued From page 5 During an observation on 3/1/22, at 10:44 a.m., Licensed Staff C was observed entering the yellow zone room without PPE, except for a regular surgical mask, looked at the residents then exited. During an interview on 3/1/22, at 9:31 a.m., Unlicensed Staff A stated she donned (put on) gown and gloves prior to entering yellow zone room but did not use N95 respirator and face shield. Unlicensed Staff A was asked the reason for not wearing N95 and face shield and she stated, Licensed Staff D told her a week ago that it was okay to use regular mask when entering the yellow zone room. Unlicensed Staff A further stated she did not change her black regular mask when she entered and exited the yellow zone room. During an interview on 3/2/22, at 9:21 a.m., Licensed Staff B was asked about PPE use in the yellow zone room. Licensed Staff B stated he donned gown and gloves prior to entering the yellow zone room and discarded it in the trash bin next to Resident 1's bed and not in the trash bin for PPE that was placed near the doorway. Licensed Staff B further stated he did not wear N95 and face shield prior to entering the yellow zone room and did not think that there would be an outcome for not wearing the proper PPE. During an interview on 3/1/22, at 10:05 a.m. and at 10:11 a.m., Licensed Staff D stated, all staff needed to wear complete PPE prior to entering rooms under transmission-based precautions (infection control used in addition to standard precaution for residents who may be infected with certain infectious agents) to prevent spread of	F 880		

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F 880	Continued From page 6 infection. A review of facility's "Personal Protective Equipment-Mitigation Plan" undated, it indicated, "D. Staff have been trained on selecting, donning and doffing appropriate PPE and demonstrate competency of such skills during resident care...E. Signs are posted outside of resident rooms indicating appropriate infection control and prevention precautions and required PPE..." A review of CDC (Centers for Disease Control and Prevention) guidance on "Evaluating and Managing Personnel and Residents" dated 2/2/22, it indicated, "HCP (Healthcare Personnel) caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH [National Institute for Occupational Safety and Health] approved N95 or equivalent or higher-level respirator)." 3. During an observation on 3/1/22, at 8:37 a.m., screening area in the lobby was observed. The temperature kiosk was difficult to take the temperature, and Unlicensed Staff G did not screen Visitor H. During an interview on 9:09 a.m., Unlicensed Staff G was asked about the facility visitor screening process. Unlicensed Staff G stated the step-by-step process and that he asked the visitor for proof of vaccination, and he signed the screening log for each visitor. Unlicensed Staff G did not mention informing the visitor to monitor for signs and symptoms of Covid-19 and what actions to take if they occur. During an interview on 3/1/22, at 12:06 p.m.,	F 880		

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F 880	Continued From page 7 Licensed Staff D was asked if the facility informed the visitors to monitor for signs and symptoms of Covid-19 and what action to take in case they occurred. Licensed Staff D stated, the receptionist "can say that" to the visitors. Licensed Staff D did not give a straight answer. During an interview on 3/1/22, at 12:16 p.m., Visitor I was asked if he was screened and asked for proof of vaccination. Visitor I stated there was no one in the lobby when he came in and he screened himself. A review of facility's "VISITORS/OTHER ANCILLARY STAFF" screening log dated 3/1/22, it did not indicate information for visitors to monitor for signs and symptoms of Covid-19 and what actions to take in case they occur.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized	F 882	1)How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were identified as being affected by the deficient practice 2) How the facility will identify other residents having the potential to be affected All residents by the same deficient practice and what corrective action will be taken; All residents have potential to be affected if the Infection Preventionist did not have proper training. Infection Preventionist had completed the Infection Preventionist training.	3/2/2022

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F 882	Continued From page 8 training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to designate a certified Infection Preventionist (IP). This failure resulted to unqualified Infection Preventionist. Findings: During an interview on 3/1/22, at 12:40 p.m., Licensed Staff D was asked for the IP Certification. Licensed Staff D provided the record that he finished the infection control training modules on 6/8/2020. Licensed Staff D stated he was not IP certified and had not taken the test yet. A review of AFL 21-51 dated 12/13/21, it indicated, "Effective January 1, 2022, AB (Assembly Bill) 1585 expands existing eligibility and minimum qualifications for SNF's (Skilled Nursing Facilities) IP...The IP must be qualified by education, training, clinical or health care experience, or certification, and must have completed specialized training in infection prevention and control."	F 882	3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recure; a) Infection Preventionist nurse had completed the Infection Preventionist training and completed the certification test on 3/2/2022. b) Director of Nursing or Administrator will validate qualifications of Infection Preventionist nurse prior to being assigned in this position. 4) How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system The Director of Nursing or Administrator will verify the Infection Preventionist Qualification/Role by reviewing the professional training, completion of the qualified education, training, experience, or certification and have completed specialized training in infection prevention and control. 5) Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. 3/2/2022	
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii)	F 887		

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F 887	Continued From page 9 §483.80(d) (3) COVID-19 Immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following:	F 887	1) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Residents 2, 3, 4, 5, and 6 have been educated and documented informed refusal is in clinical record. No adversity noted for Resident 2, 3, 4, 5, 6. 2) How the facility will identify other residents having the potential to be affected All residents by the same deficient practice and what corrective action will be taken; Any resident refusing COVID vaccine with education on benefits and risks have potential to be affected. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recure; Infection Preventionist has been re-educated on providing education to residents on risks and benefits of receiving COVID vaccine and documenting this in clinical record on 3/2/2022. Covid 19 Vaccine is added to current Immunization form to be offered upon admission and as needed together with a training material as form of education (See attached forms)	3/2/2022

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F 887	Continued From page 10 (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure resident education and refusal for Covid-19 (respiratory disease caused by SARS-CoV-2 and spread from person to person vaccination for five of the five sampled residents (Residents 2, 3, 4, 5, and 9) were documented. This failure resulted to unknown reason why Covid 19 vaccine were not provided to residents. Findings: A review of facility's list of unvaccinated residents indicated that Residents 2, 3, 4, 5 and 9 refused the Covid-19 vaccine. During a concurrent interview and record review	F 887	4) How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system Infection Preventionist will list residents receiving or refusing COVID vaccine and bring this log to QAPI (Quality Assurance Performance Improvement) committee for review and recommendations. 5) Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. 3/2/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055268	A. BUILDING _____ B. WING _____	03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SONOMA POST ACUTE	678 2ND STREET WEST SONOMA, CA 95476

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F 887	Continued From page 11 on 3/2/22, at 11:39 a.m., Immunization records for Residents 2, 3, 4, 5 and 9 were reviewed with Licensed Staff D. Licensed Staff D stated that Residents 2, 3, 4, 5 and 9 refused Covid-19 vaccination but did not document it. Licensed Staff D also mentioned that the facility did not document if Covid-19 education was provided to residents.	F 887		
F 888 SS=E	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:	F 888	1) How corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were identified as being affected by deficient practice. 2) How the facility will identify other residents having the potential to be affected All residents by the same deficient practice and what corrective action will be taken; All residents have potential to be affected if COVID vaccine protocols are not followed. 3) What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recure; a) Infection Preventionist re-educated on AFL 21-34.3 on 3/28/2022 b) Identified staff that provide declination without proper information on 3/24/2022 and the staff are removed on the schedule until the staff provide the proper information for declination is in place. The two staff identified who declined due to medical reasons are currently on medical leave. Two staff will have to show proof of medical reasons from the Physician before coming back to work from their medical leave.	3/30/22

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F 888	Continued From page 12 (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses	F 888	4) How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system Infection Preventionist will list staff receiving COVID vaccine or declining with proper requirements met to support declination and bring this log to QAPI (Quality Assurance Performance Improvement) committee for review and recommendations. 5) Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State Agency. 3/30/2022	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/14/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SONOMA POST ACUTE	670 2ND STREET WEST SONOMA, CA 95476

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F 888	Continued From page 13 as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received	F 888		

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F 888	Continued From page 14 monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (I)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure documentation for staff Covid-19 vaccination exemption was tracked and secured. This failure resulted in staff not receiving Covid-19 vaccine series and boosters without valid exemption. Findings: A review of facility's "COVID-19 VACCINE ACCEPTANCE/DECLINATION FORM" dated 9/30/21, indicated that Licensed Staff J declined "to be vaccinated, due to a qualifying medical reason-to claim this exemption you must attach a written statement by your treating physician ...indicating the probable duration of your inability to receive the vaccine, or if the duration is unknown, so indicate." During an interview on 3/1/22, at 3:28 p.m., Licensed Staff D stated, Licensed Staff J refused Covid-19 vaccine due to medical reasons but did	F 888		

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	055288	A. BUILDING _____ B. WING _____	03/02/2022

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F 888	Continued From page 15 not provide a signed statement by a licensed practitioner. A review of facility's "COVID-19 VACCINE ACCEPTANCE/DECLINATION FORM" dated 2/3/21, it indicated Unlicensed Staff K declined "to be vaccinated, due to a qualifying medical reason-to claim this exemption you must attach a written statement by your treating physician...indicating the probable duration of your inability to receive the vaccine, or if the duration is unknown, so indicate." During an interview on 3/1/22, at 3:28 a.m., Licensed Staff D stated, Unlicensed Staff K refused the second dose of Covid-19 vaccine because of an "allergic reaction" but did not provide a signed statement from a licensed practitioner. A review of the facility's "COVID-19 Vaccine Policy for Residents and Staff" dated 2/2022, it indicated, "4. Staff members that demonstrate through proper written physician certification that they have a medical contraindication to the Covid-19 vaccine may be exempted from getting the Covid-19 vaccine. A properly signed exemption form by the staff member and the staff member's written physician attestation are necessary to claim this exemption ..." During an interview on 3/1/22, at 12:23 p.m., Licensed Staff D was asked if staff who were booster eligible received their booster already. Licensed Staff D stated that not all staff received Covid-19 booster because they "didn't want the side effect." Licensed Staff D stated the staff signed the declination for the booster.	F 888		

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F 888	Continued From page 16 A review of "COVID-19 Staff Vaccination Status for Providers" that was provided to the facility and filled out on 3/1/22, it indicated that Licensed Staff L, M and S, Laundry Staff O, Housekeeping Staff P, Management Staff Q, and Unlicensed Staff N and R were completely vaccinated. A review of facility's "COVID-19 VACCINE ACCEPTANCE/DECLINATION FORM" dated 1/22/22, it indicated that Unlicensed Staff N declined the Covid-19 booster but did not indicate if it was for religious belief or medical reasons. A review of the facility's "COVID-19 VACCINE ACCEPTANCE/DECLINATION FORM" for seven staff indicated that Licensed Staff L, M and S, Laundry Staff O, Housekeeping Staff P, Management Staff Q, and Unlicensed Staff R (each previously vaccinated) refused the Covid-19 booster because of religious belief. A review of the facility's "COVID-19 Vaccine Policy for Residents and Staff" dated 2/2022, it indicated, "10. Facility will not allow existing staff members to work after March 15, 2022, if they decline vaccination and fail to provide proper exemption paperwork (medical or seriously upheld religious belief) ...15. Facility will follow the most current CDC (Centers for Disease Control & Prevention) and Local Public Health Office Covid-19 vaccination guidance...17. Facility will track and record the vaccination status of all residents and staff members as required by law." A review "State Public Health Order of December 22, 2021" with updated as of January 25, 2022, it indicated, "2. All workers currently eligible for boosters, who provide services or work in facilities...must be "fully vaccinated and boosted"	F 888		

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	055266	A. BUILDING _____ B. WING _____	03/02/2022

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F 888	Continued From page 17 for Covid-19...a. Those workers currently eligible for booster doses...must receive their booster dose by no later than March 1, 2022. Workers not yet eligible for boosters must be in compliance no later than 15 days after the recommended timeframe..." A review of "Staff Formulas" after 60 days following issuance of memo QSO 22-07-ALL, percentage current staff vaccinated for the facility was 97.8%.	F 888		

DPOC 4/1/2022 compliance
Sonoma Post Acute
678 2nd Street W
Sonoma, CA 95476

Provide training and evaluation of competencies to all staff who might have any contact with residents, on the proper COVID-19 Infection and Prevention Measures. Regarding F-880

Training was completed 3/30/2022 and targeted towards the following staff:

Licensed nurses, CNA's, Admission Representatives, Director of Nursing, Nursing Home Administrator or Executive Director, Housekeeping, Dietary, Rehab, Activity, and others.

Training provided on following topics as required:

1. Cohorting residents- Red Zone, Yellow Zone and Green Zone
2. Appropriate PPE to be worn in rooms with Transmission-based precaution
3. Visitor screening • Provide information on facility process for ensuring visitors are informed on action to take in case they develop signs and symptoms of Covid-19 after visiting the facility.

1) Competencies which included return demonstration and/or description of proper PPE to be worn with transmission based precautions, Co-horting residents, visitor screening updated, have been completed.

Develop a process that can be quantified, monitored, and evaluated for effectiveness. That will ensure all facility policies and procedures are up to date with the most current guidelines / recommendations from local, state, and federal agencies. When deviations are found describe the procedure for changing the ineffective process.

1) Policies reviewed, updated if required and deemed in place to meet current standards and practice to meet regulatory requirements. New screening tool to meet requirements has been implemented.
2) Administrator and DON are responsible to maintain current practices. AFLs, QSOs and CDC guidelines will be reviewed weekly to validate any new directives. Updates will be completed with education to staff and update policy/practice to reflect any new directives.
3) This practice will be reviewed in QAPI committee for recommendations and to assure compliance. Any deviation identified will be corrected during QAPI meeting.

Please submit requested policies and competencies along with training overview

Conduct a Root Cause Analysis (RCA) for each identified concern
Root cause identified

1) Staff failed to re-educate and identify lack of knowledge on CDC updates on screening and failed to wear proper PPE per previous training, this was not identified by observation rounds. Co-horting – upon review, was correct as reviewed resident was COVID resolved and with in 90 days of resolution without any new symptoms.

Develop a process to ensure ongoing quality assurance and education programs for each of the identified concerns.

4. DON, DSD, IP or designee will ensure that staff are assessed for competency in utilization of PPE in Transmission based precautions, Cohorting residents- Red Zone, Yellow Zone and Green Zone and for ensuring visitors are informed on action to take in case they develop signs and symptoms of Covid-19 after visiting the facility.

Education plan effectiveness will be reviewed in QAPI for review and recommendations.