STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056258	A. BUILDING _____ B. WING _____	C 10/02/2020

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WINDSOR REDDING CARE CENTER	2490 COURT STREET REDDING, CA 96001

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F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey for one facility reported incident. Facility Reported Incident: 683078 The inspection was limited to the specific facility reported incident investigated and does not represent the findings of a full inspection of the facility. Representing the Department: 22705, Health Facilities Evaluator Nurse Deficiencies were written for facility reported incident 683078 at F 624, and F 658.	F 000	"Preparation, submission and/or execution of this Plan of Correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared, submitted and/or executed solely because it is required by the provision of Federal and State law. **F 624 Preparation for Safe/Orderly Transfer/ Discharge 483.15(c)(7)** **How Corrective Action will be accomplished For Affected Residents:** Resident # 3 is no longer a resident of the facility. **Identification of other Residents with the Potential to be affected:** All residents discharging from the facility have the potential to be affected by the lack of documentation from the IDT summarizing the residents stay including a medication listing with dosage, frequency and common side effects for both prescribed and over the counter medications. **Measures put in place to prevent Recurrence:** Licensed nurses were inserviced by the Director of Nursing/Designee on information to accompany residents at the time of discharge including medications, dose, frequency, and common side effects for prescribed and over the counter medications from 10/17/20 through 10/21/20.	
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to provide a safe and orderly discharge from the facility for Resident 3, when he was not given medications as ordered by the physician or discharge instructions regarding scabies (a contagious intensely itchy skin	F 624		

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

M. Grey | Administrator | 10-23-20

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 624	Continued From page 1 condition caused by a tiny, burrowing mite. It is contagious and spreads quickly through close physical contact in a family, schools, or nursing homes)treatment. This had the potential to result in inadequate treatment, and failure to get rid of the scabies. Findings: The facility's policy titled, "Discharge and Transfer of Residents," dated 2/2018, was reviewed and indicated that to ensure that discharge planning is complete and appropriate, and that necessary information is communicated to the continuing care provider. At a minimum, the Discharge Summary/Post Discharge Plan of Care will contain a summary of the resident's status, including a description of the resident's medication therapy, allergies, adverse reactions, licensed nurse's discussion with the resident/resident representative regarding their pre-SNF placement medications, and reconciliation to post discharge medication regimen. This will include documentation from the IDT regarding transfer, or discharge and the following information as applicable. All medications, including all prescription and over the counter medications to be taken with information on dosage, frequency of administration, and recognition of common side effects. Resident 3's record was reviewed, and indicated that he had complained of severe itching all over, and had burrow like areas with track marks identified on 3/30/20. Ivermectin (a medication	F 624	**Monitoring Performance to Ensure Solutions are sustained:** Medical Records will review the discharge/ transfer sheet for completeness by the IDT and report findings to the IDT team. Omissions will be followed up Social Service/ Nursing with a telephone call to the patient/family and a revised discharge notice will be mailed out by Social Services including medication instruction.. The Director of Nursing/Designee will randomly review discharge instructions given by the licensed nurses when residents are discharged. The Director of Nursine will provide additional education as needed based on reviews and report to the QA and A committee monthly for three months and or until substantial compliance is achieved. **Completion Date: 10/21/20**	

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F 624	Continued From page 2 that treats parasites) was ordered and given on 3/30/20. Elimite cream (topical medication given to treat scabies) was ordered to be administered to the full body, and be repeated in seven days. It was administered on 4/1/20, then Resident 3 was discharged home on 4/2/20. Resident 3's record contained no note regarding when the the second dose of elimite treatment should be administrated. A copy of the post discharge plan of care did not include any information about scabies, and did not include a medication list. During a concurrent interview, and record review, on 8/31/20 at 3:15 pm, Infection Control Nurse (ICN) confirmed that the discharge instructions given to Resident 3 included a note, that read "see med list," but there was no med list included. He said he did not know what Resident 3 was told about the elimite cream. He said a copy of the med list should have been kept to show what the resident was told, and if he was given the medication at the time of discharge.	F 624		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that services provided by the facility were outlined in the residents comprehensive care plans, or that they meet professional standards of quality a scabies (tiny, burrowing mite. It is contagious and spreads	F 658	**F 658 Services Provided Meet Professional Standards 483.21 (b)(3)(i)** **How Corrective Action will be accomplished For Affected Residents:** There are no current reporting's of/ or evidence of any resident In the facility with scabies. **Identification of other Residents with the Potential to be affected:** All residents of the facility have the potential to be exposed to an outbreak of scabies. **Measures put in place to prevent Recurrence:** 1-2. The new IP Nurse was educated by the Current Director of Nursing on 10/19/20 purposes of a surveillance collection data form, the facility document library where infection control policies and procedures related to scabies can be found. Licensed nurses were educated by the Director of Nursing/Designee 10/19/20 through 10/21/20 on care planning resident changes in condition ie. suspected scabies, treatment monitoring/ documentation of rash, signs and symptoms of scabies. 3. The Director of Staff Development inserviced CNA staff the proper cleaning and disinfecting of reusable equipment, such as shower chairs, relaying the potential to spread a scabies infliction on 10/19/20 through 10/21/20. 4. The Director of Nursing/Designee inserviced licensed nurses 10/19/20 through 10/21/20 following Physician orders and notification to Physician if those orders are not carried out and why. **5.** Licensed nurses were inserviced by the Director of Nursing/Designee on information to accompany residents at the time of discharge including medications, dose, frequency, and common side effects for prescribed and over the counter medications from 10/19/20 through 10/21/20.	

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F 658	Continued From page 3 quickly through close physical contact in a families, schools, or nursing homes) outbreak, affecting 13 of 95 residents (Residents 1-13) and five healthcare workers. The facility did not follow its Scabies policy and procedure including the California Department of Public Health (CDPH) guidelines relating to scabies control when: 1. The surveillance data collection form did not include all necessary and accurate information. 2. Skin scrapings were not done in accordance with the guidelines. 3. Equipment used between residents was not cleaned properly. 4. One of 13 residents (Resident 5) did not receive all treatment for scabies as ordered by the physician. 5. One of 13 residents (Resident 3) did not receive information regarding scabies, and further medication to treat scabies when he was discharged, prior to the completion of treatment. This had the potential to result in the spread of scabies to more residents who resided in the facility, as well as staff, and continuation of the scabies outbreak. Findings: The facility's policy titled, "Scabies," dated 1/1/2014, was reviewed and indicated that the	F 658	**Monitoring Performance to Ensure Solutions are Sustained:** The Director of Nursing will review the surveillance logs prepared by the IP Nurse weekly for three months. Medical Records will review the discharge/ transfer sheet for completeness by the IDT and report findings to the IDT team. Omissions will be followed up Social Services/ Nursing with a telephone call to the patient/ family and a revised discharge notice with medication instruction for the resident and family will be mailed out by Social Services. The IP Nurse will present and discuss Surveillance logs at monthly Infection Control QA and A meetings. Medical Records will present results of audits For residents discharges/ transfer sheet Monitoring for three months to the QA and A Committee. **Completion Date:** 100/21/20	

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F 658	Continued From page 4	F 658		

facility works to prevent the spread of scabies in the facility by strictly adhering to the standards set out by the Centers for Disease Control and Prevention, and State of California Department of Public Health. The Infection Control Coordinator will follow the guidance provided in the following publications to prevent and minimize the outbreak of scabies.

A facility document titled, "Management of Scabies Outbreaks in California Health Care Facilities," dated 3/2008, was reviewed and indicated that scabies infestations are generally categorized as typical, atypical, or crusted/keratoic (Norwegian). Persons with typical scabies generally have fewer than 50 lives mites on their skin at any given time. Therefore typical scabies is difficult to transmit from patient to healthcare worker, unless there is prolonged, unprotected skin to skin contact. In contrast, persons with with atypical or crusted scabies harbor hundreds to millions of mites in multiple skin burrows or in layers of crusted lesions. Healthcare workers who have unprotected skin to skin contact with any patient with atypical or crusted scabies will commonly develop scabies following exposure. To confirm the diagnosis, if atypical or crusted scabies is suspected at least one skin scraping should be done. If the first scraping is negative, scrapings should be done until at least one skin scraping is positive for mites, fecal pellets, or eggs. Six negative scrapings in a patient with suspected atypical, or crusted scabies should lead to reconsideration of the diagnosis. The infection control practitioner should develop a surveillance data collection form for specifically investigating the scabies outbreak. The following should be collected on all healthcare workers; date of onset of symptoms,

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F 658	Continued From page 5 body site affected, recommenced treatment, date of treatment, follow-up evaluations and dates. The following should be collected on all patients who are diagnosed, clinically symptomatic, or who may have been exposed to a scabies case;symptoms (rash, pruritis, etc.); classified as typical, atypical, or crusted scabies, date of onset of symptoms, date of skin scrapings, results of skin scrapings (positive, negative, or not done), date of first treatment, treatment provided, date of second treatment, if recommended, follow-up treatment, and/or evaluation and dates. The facility notified the Department of a possible scabies outbreak on 3/30/20. In a follow up letter, dated 3/31/20, the facility noted that skin inspections were done for all residents in the facility, and several had rashes, and would be treated with ivermectin (oral scabies treatment) or elimite (permethrin, topical cream treatment for scabies) as ordered. 1. a. A review of the surveillance collection data form, provided by the former Director of Nurses (DON) on 5/21/20, and Resident 1-13's record were reviewed. The collection data form and the notes contained in the record did not include two or more of the following: a description of the rash, its classification (typical, atypical or crusted scabies), itchiness, or location of the rash for Residents 1, 2, 4, 5, 6, 7, 8, 9, 10, and 13. During a concurrent interview, and record review on 8/31/20 at 1:50 pm, the Infection Control Nurse (ICN) confirmed the above information was missing from the collection data surveillance form.	F 658		

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F 658	Continued From page 6 b. The collection data form indicated Residents 1-11, and Resident 13 received both elimite cream and ivermectin as treatment for scabies. Resident 12 refused all treatment. The records including physician orders and medication administration records were reviewed for Residents 1-13. Residents 6, 7, 8, 9, 10, received only the ivermectin as treatment. There was no physician's order for the elimite. Resident 13 received only the elimite cream. There was no physician's order for the ivermectin. During a concurrent interview, and record review, on 8/31/20 at 1:50 pm, ICN confirmed the above information. He said he thinks the former DON included both medications on the data collection surveillance form, because that had been her plan, as opposed to it having actually occurred. c. The collection data form included the names of five healthcare workers who were treated and the medications they received. The form did not include the symptoms including rash, rash description, and location of the rash. During an interview, on 8/31/20 at 3:30 pm, Licensed Nurse (LN) 1 said she had a rash on her arms and back, and was treated with ivermectin and elimite cream, and the rash cleared up in about three to five days. She said the former ICN looked at her and thought the rash looked like scabies. LN 1 said she did not recall which resident from which she may have gotten the scabies. 2. A review of Resident 11's record indicated he had been admitted, with a rash, on 3/11/20. A	F 658		

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F 658	Continued From page 7 progress note, dated 3/25/20, from the physician caring for his wound, indicated possible Norwegian scabies, and a skin biopsy was done. A review of the skin biopsy on Resident 11 indicated spongiotic dermatitis (skin irritation involving fluid buildup in the skin), probably contact dermatitis, excoriated. These changes are identical to those of nummular dermatitis (rash or sore that my occur after an injury), spongiotic arthropic (insects including scabies) bite reaction and spongiotic drug reaction. During an interview, on 5/21/20 at 3:30 pm, ICN confirmed after the physician's assessment of Resident 11, skin inspections were done on all residents who resided in the facility. A review of the skin scraping on Resident 12 indicated, negative for fungal elements, negative for budding yeast, no sarcoptes (scabies) mites or ova (eggs) seen. During an interview, on 8/31/20 at 1:50 pm, ICN confirmed one skin scraping was done on Resident 12 but it didn't show anything. One tissue biopsy was done on Resident 11 but was inconclusive. No other skin scrapings were done. He said scabies was not confirmed but many residents were treated for scabies based on symptoms. 3. During an interview on 5/21/20 at 3:45 pm, the ICN said, the nurse who was the former ICN, investigated the outbreak. It was her conclusion that the shower chair may have been the source for the spread, since the rash for some residents, was in the area where it would be if one sat in a shower chair. Another possible source was the	F 658		

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F 658	Continued From page 8 smoking area. ICN said they were now monitoring to make sure the shower chair was properly cleaned between residents. 4. During a concurrent interview, and record review, on 8/31/20 at 1:50 pm, ICN said Resident 5 received ivermectin as ordered. There was also a physician's order for elimite cream but it was not given to Resident 5. He said there was no documentation regarding notification to the physician about not giving the medication, although there should have been. 5. A review of Resident 3's record indicated he complained of severe itching all over and had burrow like areas with track marks identified. Ivermectin was ordered and given on 3/30/20. Elimite cream was ordered to be administered to the full body and repeated in seven days. It was administered on 4/1/20, then Resident 3 was discharged home on 4/2/20. No note regarding the second dose of elimite could be located in the record. During a concurrent interview, and record review, on 8/31/20 at 3:15 pm, ICN said the discharge instructions given to Resident 3 included a note, "see med list," but there was no med list. He said he did not know what Resident 3 was told about the elimite cream. He said a copy of the med list should have been kept to show what the Resident was told and if he was given the medication at the time of discharge.	F 658		