Statement of Deficiency

Sonoma Post Acute (678 2nd St W Sonoma)

SR SNF COVID-19 Mitigation

Managers
[redacted]

Inspection Date
Oct 27, 2020

Report Sent Date	Done Date	Reference ID	Status
Nov 3, 2020	Nov 17, 2020	JN6L11	Done

Notes

Dear Administrator:

Enclosed is a Statement of Deficiencies, which resulted from a recent visit to your facility. Please use the Risk and Safety Solutions program to prepare an electronic plan of correction for each deficiency within ten (10) calendar days from receipt of this Statement of Deficiencies. You can download a PDF copy of the Statement of Deficiencies and your Plan(s) of Correction or access the electronic record at any time.

The Plan of Correction for each deficiency must contain the following:

a) What corrective action(s) will be accomplished for the patient(s) identified to have been affected by the deficient practice.
b) How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken.
c) What immediate measures and systemic changes will be put into place to ensure that the deficient practice does not recur.
d) A description of the monitoring process and positions of persons responsible for monitoring (i.e., Administrator, Director of Nursing, or other responsible supervisory personnel). How the facility plans to monitor its performance to ensure corrections are achieved and sustained. The plan of correction must be implemented, corrective action evaluated for its effectiveness, and it must be integrated into the quality assurance system.
e) Dates when corrective action will be completed. The corrective action completion date must be acceptable to the Department. The deficient practice should be corrected immediately. This date shall be no more than 30 calendar days from the date the facility was notified of the non-compliance.

If your Plan of Correction is unacceptable to the Department you will be notified in writing through the Risk and Safety Solutions program. You are ultimately accountable for compliance, and responsibility is not alleviated where notification of the acceptability of the plan of correction is not timely. Your plan of correction will serve as the facility's allegation of compliance.

If an acceptable plan of correction is not received within ten (10) calendar days from receipt of the Statement of Deficiencies, the Department will recommend to the regional office and/or the State Medicaid Agency that remedies be imposed as soon as the notice requirements are met.

If you have any questions, please contact Supervisor, [redacted]

The following reflects the findings of the California Department of Public Health during a COVID-19 SKILLED NURSING FACILITY MITIGATION PLAN IMPLEMENTATION MONITORING SURVEY.

A COVID-19 Mitigation Plan Implementation Survey was conducted by the California Department of Public Health on 10/27/2020.

Representing the Department of Public Health:
HFEN 39621

The facility was found not to be in compliance with Title 22 California Code of Regulations section 72523(c) patient care polices and procedure regulations and has not implemented the Skilled Nursing Facility Mitigation Plan for COVID-19.

Representing the California Department of Public Health:

34331, Health Facilities Evaluator Supervisor (HFES)

Total Residents: 74

TWO DEFICIENCIES WERE IDENTIFIED.

[redacted]

Mitigation-Testing and Cohorting *

Mitigation-Infections Prevention Control *

The SNF has a full-time, dedicated Infection Preventionist(s). This can be achieved by more than one staff member sharing this role, but a plan must be in place for infection prevention quality control. SNF will list the names and positions of staff assigned to infection prevention for the facility.

Survey Procedures:
- Interview staff identified as dedicated infection preventionist to discuss the training and infection control practices at the facility.
- Review documentation of the training for staff serving as he SNFs infection preventionist.

Public Comments:

[redacted]: [redacted].

Tags: § 72321 (b) § 72523(c)(3)

Status: Compliant

An infection control lead has been designated to address and improve infection control based on public health advisories (federal and state) and spends adequate time in the building focused on activities dedicated to infection control.

Survey Procedures:
Interview the infection control lead and ask for information about the time spent focused on infection control activities and what activities were completed (i.e. surveillance, education adherence monitoring).

Public Comments:

[redacted]: [redacted]

Tags: § 72321 (b) § 72523(c)(3)

Status: Compliant

The SNF must ensure HCPs receive infection prevention and control training.

Survey Procedures:
Review documentation of staff training records

Public Comments: Based on observation, interview and record review, the facility failed to ensure two Certified Nursing Assistants (Unlicensed Staff A and Unlicensed Staff B) had knowledge of the process for disinfecting patient care equipment properly, based on manufacturer's instructions. This failure had the potential to result in breaks in infection control, and spread of infections including COVID-19 among staff and residents in the facility.

Findings:

During an interview with Unlicensed Staff A, Certified Nursing Assistant, on 10/27/20 at 10:00 a.m., in the yellow isolation unit of the facility (Isolation area housing residents potentially exposed to COVID-19, or newly admitted to the facility), Unlicensed Staff A was asked their process for disinfecting vital signs equipment shared by the residents in the isolation area. Unlicensed Staff A stated she used [brand] wipes and presented the bottle, which contained the wipes. Unlicensed Staff A was asked for how long she kept the equipment wet for disinfection before proceeding to use it with a different resident. Unlicensed Staff A stated she waited about a minute, which was the approximate time it took the equipment to dry before reusing the equipment. The Director of Nursing (DON), who was present during the interview, stated staff in the isolation had only recently started using these wipes for disinfection and were previously using a different brand of disinfecting wipes.

During an interview with Unlicensed Staff B, Certified Nursing Assistant on 10/27/20 at 10:42 a.m., he was asked the process for disinfecting shared equipment, such as blood pressure cuffs. Unlicensed Staff B also referred to the same disinfection wipes mentioned by Unlicensed Staff A for disinfecting the equipment. Unlicensed Staff B was asked for how long the equipment had to be wet in order for the equipment to be disinfected properly. Unlicensed Staff B stated he did not know, and had not received training on it.

The Infection Preventionist (IP) provided evidence of a staff training conducted on 8/11/20 that included disinfection times of equipment, however; during an interview on 10/27/20 at 11:45 a.m., the IP stated the facility used different disinfecting wipes around the time of the training, and had started using the disinfecting wipes in current use (mentioned by Unlicensed Staff A and Unlicensed Staff B) at the beginning of September, 2020. The IP was unable to provide evidence of training on disinfection of equipment after the facility started using the current disinfection wipes.

The bottle of wipes mentioned by Unlicensed Staff A and Unlicensed Staff B had the following indications for use, “TO DESINFECT: Use to disinfect hard, nonporous surfaces. Wipe surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for 4 minutes. Let surface dry.”

The California Department of Public Health AFL 20-14 (All Facility Letter), a letter from the Licensing and Certification (L&C) Program to health facilities that are licensed or certified by L&C, directed all facilities, on 02/19/20, “For persons under investigation and patients managed with transmission-based isolation precautions for COVID-19, the CDC (Centers for Disease Control and Prevention-A national public health institute in the United States) guidelines recommends the following environmental infection control measures: All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer’s instructions and facility policies. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.”

The facility's Mitigation Plan approved by the DEPARTMENT on 8/04/20 at 12:27 p.m., indicated, "The facility will ensure staff receive infection prevention and control training."

[redacted]:

[redacted]

Tags: § 72321 (b) Scope & Severity D

Status: Not Compliant

Resolution:

Resolved

Resolved on Nov 17, 2020

Updated on Nov 17, 2020

POC accepted. Thank you.

Ready For Verification

Updated on Nov 17, 2020

This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not

EXPECTED DATE OF COMPLETION 11/3/2020

constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied
72321 (b)

1) All Staff including Staff A and Staff B identified in the statement of deficiencies have been RE educated re: reading the labels of the disinfectants for dwell time.
2) The Infection Preventionist (IP) re educated staff to insure awareness of changing the supply of disinfectants and using them according to the manufacturer recommendation
3) The IP will insure all staff are aware of any new products provided and the proper way to use them
4) The IP will continue to monitor for staff compliance following this re education
5) Any further issues will be brought to Quality Assurance Committee meetings.

Not Resolved

Updated on Nov 17, 2020

Please upload POC directly into RSS system (Do not add it as an attachment). Thank you.

Ready For Verification

Updated on Nov 14, 2020

Documents:

Revised POC.docx
Download

Not Resolved

Updated on Nov 12, 2020

POC not accepted. Please delete, "1) The Resident in question who perhaps prompted the surveyor question re: disinfecting the vital signs equipment between residents has his OWN, separate from others vital signs equipment." The resident with C-Diff did not prompt me to ask staff the process for disinfecting VS equipment- that is a standard question asked during every Mitigation Plan Survey, and the fact that he has his own VS equipment does not protect other residents, who do share equipment.
Also, not only should the staff who did not know the process for disinfecting patient care equipment correctly be in-serviced, but all the staff who have to disinfect patient care equipment as part of their duties. Once they have been in-serviced, please attach the training sing-in sheets to this POC as evidence. Thank you.

Ready For Verification

Updated on Nov 5, 2020

Documents:

POC 11:3:2020.docx
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Updated on Nov 5, 2020

Documents:

POC 11:3:2020.docx
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Incident Attachments:

Documents:

AFL-20-14.pdf
Download
Sonoma Post Acute-Photographs.docx
Download
Sonoma Post Acute-In-Service Sing-In Sheet.docx
Download
Sonoma Post Acute-Mitigation Plan pg. 6.pdf
Download

The SNF screens and documents every individual entering the facility (including staff) for COVID-19 symptoms. Proper screening includes temperature checks.

Survey Procedures:
Observe their screening process and request to see their screening documentation for all staff and visitors to the facility.

Public Comments: Based on observation, interview and record review, the facility failed to implement their Mitigation Plan when a visitor was not screened for all signs and symptoms of COVID-19 upon entrance to the facility and no documentation was provided indicating other visitors were screened for all signs and symptoms of COVID-19, per the Centers for Disease Control and Prevention (CDC- A national public health institute in the United States) guidelines. This failure had the potential to result in transmission of the virus to the staff and residents in the facility.

Findings:

During entrance to the facility on 10/27/20 at 9:45 a.m., the facility's Infection Preventionist (IP) greeted Health Evaluator Nurse C at the door and allowed her into the facility. Health Facilities Evaluator Nurse C was asked by the IP to sanitize her hands, take her temperature, and fill out a document titled, "VISITOR SCREENING FOR COVID-19," located in the receptionist desk, upon entrance to the facility. This document asked for travel history, temperature, and the following COVID-19 symptoms, "COUGH/SNEEZE/SHORTENESS OF BREATH/SORE THROAT/BODY ACHE." No other COVID-19 symptoms were included in the form. No other symptoms of COVID-19 were verbally asked, nor was a list of all possible symptoms of COVID-19 presented to Health Facilities Evaluator Nurse C. The IP proceeded to direct Health Facilities Evaluator Nurse C to a conference room to initiate the Mitigation Plan survey.

During an observation on 10/27/20 at 10:13 a.m., it was noted the facility had a separate form to screen employees for signs and symptoms of COVID-19 titled, "EMPLOYEE SCREENING FOR COVID-19." This form inquired about the following symptoms of COVID-19, "COUGH/ACTIVE SNEEZING/SORE THROAT/FEVER/NEW SKIN ISSUES/VOMITING/DIARRHEA/LOSS OF SENSE OF SMELL OR TASTE BODY ACHES/SHORTNESS OF BREATH."

During an interview with the facility's Director of Staff Development (DSD) on 10/27/20 at 10:15 a.m., she was asked the reason for having more COVID-19 symptoms listed on the employee screening form versus the visitor screening form. The DSD stated the symptoms not listed in the visitor screening form were verbally asked by the receptionist to all visitors entering the facility. The Director of Nursing (DON), who was also present, stated the facility had a list of all COVID-19 symptoms that they presented to the visitors upon entrance and stated the facility receptionist verbally inquired about those symptoms. The DON presented a document with a list of COVID-19 symptoms filed at the back of a binder filled with documents. The list was not present in the receptionist desk, or in view upon entrance to the facility, prior to the DON presenting this document to Health Facilities Evaluator Nurse C on 10/27/20 at 10:15 a.m.

The facility document titled, "VISITOR SCREENING FOR COVID-19," located in the receptionist desk, indicated four visitors had entered the facility on 10/27/20 prior to Health Evaluator Nurse C. There was no documented evidence these visitors were screened for symptoms of COVID-19 other than those listed in the form titled, "VISITOR SCREENING FOR COVID-19," which did not include a comprehensive list of known symptoms per CDC guidelines.

The California Department of Public Health AFL 20-22.5 (All Facility Letter), a letter from the Licensing and Certification (L&C) Program to health facilities that are licensed or certified by L&C, directed to Long-Term Care Facilities, on Oct 23, 2020, indicated, "This AFL authorizes LTC (Long Term Care) facilities to temporarily modify their facility's visitation policies in accordance with CMS (The Centers for Medicare & Medicaid Services- A federal agency that administers the nation's major healthcare programs including Medicare and Medicaid) and CDC COVID-19

guidance when necessary to protect the health and safety of residents, staff, and the public... Ensure screening of all who enter the facility for fever and COVID-19 symptoms."

A document titled, "Symptoms of Coronavirus," published on 5/13/20 by CDC indicated, "People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. People with these symptoms may have 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."

The facility's Mitigation Plan approved by the DEPARTMENT on 8/04/20 at 12:27 p.m., indicated, "The facility screens and documents every individual entering the facility (including staff) for COVID-19 symptoms and temperature."

[redacted]:

[redacted]

[redacted]

[redacted]

Tags: § 72523(c)(3) Scope & Severity E

Status: Not Compliant

Resolution:

Resolved

Resolved on Nov 17, 2020

Updated on Nov 17, 2020

POC accepted. Thank you.

Ready For Verification

Updated on Nov 17, 2020

This Plan of Correction is submitted as required under Federal and State regulation and statues applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope or severity regarding any of the deficiencies cited are correctly applied

EXPECTED DATE OF COMPLETION 11/3/2020

72523 (c)(3)

1) New log that includes ALL symptoms has been put out for visitors and staff to sign in with. As new symptoms become known, they will be added.
2) The receptionist (day 1 on the job) and the IP were reminded that even if the health provider may be assumed to know all COVID-19 symptoms to still insure asking ALL the screening questions.
3) The actual form that is used by visitors to screen for Covid 19 symptoms was updated to reflect ALL the symptoms.
4) The IP will continue to spot check the receptionist consistency since she is a new hire.
5) Further issues will be brought to QAPI.

Not Resolved

Updated on Nov 17, 2020

Please upload the POC directly into the RSS system, do not add it as an attachment. Thank you.

Ready For Verification

Updated on Nov 14, 2020

Documents:

Revised POC.docx
Download

Not Resolved

Updated on Nov 12, 2020

POC not accepted. Please review the following sections of your POC:

1) It is not unusual for facility staff to feel nervous and at times awkward around HFENs.
2) The surveyor was asked the questions screening for COVID symptoms just like all visitors. It is unfortunate that she does not recall being asked about the nausea, vomiting diarrhea question.

3) The laminated sheet with the all the screening symptoms continues to be affixed to the top of the reception counter; just like before the surveyor entered.

This surveyor was NOT asked for symptoms regarding Nausea, Vomiting, Etc. This is not a matter of not recalling, everything I was asked for, was documented, so this problem of "not recalling" does not happen. A POC is not a place to argue or discuss a deficiency you do not agree with. Follow the IDR process if you do not agree with the deficiency. The list of signs and symptoms of COVID-19 was NOT on top of the counter when this surveyor entered the facility, not was it shown to this surveyor upon entrance. Please provide evidence that receptionists or staff assigned to screen visitors are aware that they have to screen all visitors for all symptoms of COVID-19 based on CDC guidance, and attach the sign-in sheet as evidence. Also, attach the new screening form as evidence. Thank you.

Ready For Verification

Updated on Nov 5, 2020

Documents:

POC 11:3:2020.docx
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Updated on Nov 5, 2020

Documents:

POC 11:3:2020.docx
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Incident Attachments:

Documents:

Sonoma Post Acute-Mitigation Plan pg. 6.pdf
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Sonoma Post Acute-Employee and Visitor Screening Forms.pdf
Download
CDC-Symptoms of COVID-19.pdf
Download
AFL 20-22-5.pdf
Download

The designated infection control lead maintains a line list of all patients who have been confirmed to meet clinical criteria of presumed COVID-19 including testing and results.

Survey Procedures:
Request to see the list of confirmed patients

Public Comments:

Private Comments: List maintained. Requirement met.

Tags: § 72321 (b) § 72523(c)(3)

Status: Compliant

The facility must submit a copy of the facility's infection prevention quality control plan.

Survey Procedures:
Review the facility's infection prevention quality control plan and verify that the facility is implementing the plan.

Public Comments:
Private Comments: Infection Prevention Quality Control Plan reviewed. No issues noted.
Tags: § 72321 (b) § 72523(c)(3)
Status: Compliant

Mitigation-Personal Protective Equipment (PPE) *

Mitigation-Staffing Shortages *

Mitigation-Designation of Space *

Mitigation-Communication *

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]