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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055854	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Santa Rosa Post Acute	4650 Hoen Avenue Santa Rosa, CA 95405

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38322 Based on observation, interview, and record review, the facility failed to appropriately respond to a scabies (a burrowing mite that causes an itchy rash; it can spread from person to person in crowded living situations such as nursing homes) outbreak that resulted in 41 out of 95 residents developing an itchy rash when the infection preventionist did not implement surveillance for potential cases of scabies when rashes began appearing, did not identify the scabies outbreak, and did not report the scabies outbreak to the local health department (LHD) per Centers for Disease Control and Prevention (CDC) guidance. This failure potentially delayed additional resources and assistance from the local health department to prevent scabies from spreading to all 95 residents and delayed the LHD from investigating potential exposures and further spread in the community. Findings: During an interview on 11/14/24 at 1:35 p.m. with Director of Nursing (DON) and Infection Preventionist (IP), DON stated that during a heat wave in September (2024) residents started developing a mysterious rash. DON stated they tried treating the rash with various treatments such as hydrocortisone cream (a steroid cream that treats swelling and itching) and chlorhexidine (an antiseptic that treats skin infections). DON stated many were treated prophylactically (action taken to prevent disease) for scabies with permethrin (a cream applied to the skin to kill the scabies mites). DON stated that when family members heard the word scabies (when giving permission for the prophylactic treatment) they would insist that scabies was what caused their loved one's rash. DON stated one resident, Resident 1, tested positive for scabies when a burrowing mite was found on his foot while he was in the hospital on 9/30/24. DON stated that since Resident 1 was the only confirmed case of scabies, she was taking a conservative approach. DON stated that if there had been two residents who tested positive for scabies, she would have treated all the residents and staff for scabies. IP stated none of the facility's residents were currently on contact isolation, except for one resident who was positive for Covid. (continued on next page)

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.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a phone interview on 11/19/24 at 1:39 p.m., confidential family member 4 (FM4) stated her mom was recently sent to a local acute care hospital, and while she was there, she asked the doctor if he could diagnose her mom's rash. FM4 stated the next day she went to visit her mom in the hospital and the nurses told her she needed to gown up before going in the room because her mom had scabies. FM4 stated she did her mom's laundry and developed an itchy rash. FM4 stated she went to her dermatologist and was prescribed a scabies treatment. When queried, FM4 stated the dermatologist did not do a skin scrape, just looked at the rash. FM4 stated she was concerned about Resident 11 who wandered in the facility and might be spreading scabies. FM4 stated she had seen Resident 11 get in bed with her mom and another time she got in bed with Resident 1. FM4 stated she had also seen Resident 11 go through other resident's belongings. During a phone interview on 11/19/24 at 2:09 p.m., confidential family member 5 (FM5) stated the DON told her that there was one case of scabies, but they had to have two cases before they treated it like an outbreak. FM5 stated it was awful that anyone in the facility should have to wait six months before anyone got anything done (about the spread of scabies). During an interview on 11/19/24 at 2:45 p.m., Resident 6 verified he had a rash recently. Resident 6 stated, I was so itchy I went to the doctor. I spread a lotion all over and that took care of it. Review of Resident 6's electronic medical record revealed his face sheet indicated an initial admitted [DATE]. Review of Resident 6's physician progress note dated 10/14/24 indicated, RASH: Pruritic (itchy), papular (small bumps), erythematous (red), with apical (tips of bumps) crust rash scattered over trunk and extremities, present intermittently since 07/09/24. Minimal improvement with triamcinolone 0.1% . Review of Resident 6's October 2024 MAR indicated Resident 6 received permethrin cream 5% treatment on 10/2/24 and 10/9/24 with instructions, Apply head to toe except face topically one time a day for Scabies treatment . During an interview on 11/20/24 at 11:26 a.m., Resident 8 verified she had had a rash recently, but stated she was feeling run down and did not provide any more information. During an interview on 11/21/24 at 10:14 a.m., when asked about the rash residents were experiencing, Licensed Nurse A stated a lot of residents were treated prophylactically with permethrin and ivermectin. Licensed Nurse A stated he was not sure if the residents were tested for scabies. Licensed Nurse A stated a lot of the families heard the word scabies and saw a rash on a loved one and assumed it was scabies and asked for treatment. When queried, Licensed Nurse A stated he did not know the reason the residents were not tested . During an interview on 11/21/24 at 10:22 a.m., Licensed Nurse B stated none of her residents had had a scabies diagnosis, just an active rash which was treated prophylactically. Licensed Nurse B stated the residents' families see a rash and they say scabies! Scabies! They go crazy. Licensed Nurse B stated the rash was because it was hot, no one confirmed it's scabies. They hear scabies and everyone feels like they have it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident 7's electronic medical record revealed her face sheet indicated an admitted [DATE]. Review of Resident 7's physician progress note dated 10/10/24 revealed, Continued rash along various [lower extremities], [upper extremities] surface, pinpoint and excoriated (scratched) . Assessment and Plan: . initially felt rash not [consistent with] scabies, but on second review cannot exclude given papular/pustular (pus-filled blisters) outbreak on [lower extremities] . overall high risk given lives in shared facility and symptoms have persisted even with topical steroids, therefore, discussed with daughter indicated to treat it as scabies . Review of Resident 7's hospital discharge summary note, dated 10/21/24, indicated Resident 7 was in the hospital from 10/15/24 to 10/21/24 and was treated for scabies while admitted . Further review of Resident 7's discharge summary indicated Scabies under section titled Final Diagnoses. During a phone interview on 11/22/24 at 9:20 a.m., LHD Nurse stated her department had not received a call from the facility regarding scabies. LHD Nurse verified the facility was expected to notify the LHD if they had an outbreak of scabies. LHD Nurse stated it would be recommended that the facility test a couple more people. LHD Nurse stated that if a resident's doctor documented that the rash was scabies in their notes without a skin scrape, the resident was considered positive. LHD Nurse stated the doctor's documentation of scabies was considered a diagnosis. LHD Nurse stated, We would expect them (the facility) to reach out to us in this case. LHD Nurse stated her department had had outbreaks before where they were only able to skin scrape one person. When queried, LHD Nurse stated an outbreak was considered two or more confirmed cases, or one confirmed and two suspected cases. LHD Nurse stated that even without the skin scrapings the facility would meet that definition. LHD Nurse stated their recommendations would include to put residents in isolation for the first treatment until after the shower, do a facility-wide treatment but that would be their choice, the facility IP should contact everyone who had physical contact with each case, and a healthcare provider should do frequent and thorough skin checks on all patients. LHD Nurse verified that would be the physician, nurse practitioner, or physician assistant doing the skin checks. LHD Nurse verified the LHD disease control section would have also wanted to know that three residents with confirmed or suspected scabies had been in local hospitals for several days while experiencing itchy rashes. During a phone interview on 11/22/24 at 2:50 p.m., LHD Nurse stated the permethrin cream treatment had no lasting effect, so residents could be reinfected pretty quickly after the treatment was applied. During an interview on 12/2/24 at 2:20 p.m., Licensed Nurse C verified that Resident 11 did have a wandering behavior. Licensed Nurse C stated Resident 11 had dementia, the staff needed to redirect her, and she was hard of hearing, but she was constantly taking out her hearing aids, which made it really hard to redirect her. Licensed Nurse C stated Resident 11 was looking for her mom or her family, going in and out of other residents' rooms, it's a problem. Licensed Nurse C stated that a couple of months ago Resident 11 went in another resident's bed. Licensed Nurse C stated Resident 11 would also go through other residents' clothes. When queried, Licensed Nurse C stated the rash the facility residents had been experiencing began in the summertime, maybe in July (2024). The doctors said it was heat rash because it was hot. When asked if it was hot inside the facility, Licensed Nurse C stated it was just hot weather, but not hot inside. Licensed Nurse C stated they applied other creams, but they were not successful, so it was hard to figure out. Licensed Nurse C stated the rash would come back after two weeks, so they suspected scabies, we couldn't believe it was actually scabies. (continued on next page)

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