STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555731	A. BUILDING _____ B. WING _____	**08/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEPT OF STATE HOSPITALS - METROPOLITAN SNF	**11401 SOUTH BLOOMFIELD AVENUE NORWALK, CA 90650**

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 -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility failed to follow it's own policy and procedure to contain the spread of COVID 19 when: 1. The medication nurse (PT - Psychiatric Technician) failed to wear a face shield as required in the COVID 19 Positive Isolation Unit (Unit 418). 2. Facility staff failed to discard isolation gowns after removal in a dedicated container in Unit 418. 3. The facility failed to ensure ABHR (Alcohol Based Hand Rub) was available by the exit door area designated for removal of all PPEs (Personal Protective Equipment) prior to exiting the COVID 19 Positive Isolation Unit (Unit 418). These failures placed all residents and staff at risk for contracting COVID 19 and other communicable diseases and infections. Findings: 1. During an observation conducted in the COVID 19 Positive Isolation Unit (Unit 418), on 8/5/20 at 12:05 PM, the medication nurse (PT) was pushing a medication cart in the hallway. The medication nurse was observed not wearing a face shield. When asked why she was not wearing a face shield, she stated, I will go get one. During a concurrent interview with the NC (Nursing Coordinator), he stated all staff should wear a face shield upon entering the isolation unit. A review of the facility policy dated 4/9/20, titled, .COVID 19 NURSING PROTOCOL: DONNING (PUTTING ON) PPE, indicated, .Put on eye protection (ie., goggles, or a disposable face shield that covers the front and sides of the face) upon entry to the patient room or care area. Personal eye glasses and contact lenses are NOT considered adequate eye protection. 2. During an observation conducted in the COVID 19 Positive Isolation Unit (Unit 418), on 8/5/20 at 12:15 PM, a small black trash can was over filled with blue isolation gowns and was stored outside of the nursing station door. During a concurrent interview with the NC, he stated the isolation gowns should have been discarded in the appropriate covered trash barrel. A review of the facility policy dated 4/9/20, titled, .COVID 19 NURSING PROTOCOL: DOFFING (REMOVING) PPE, indicated, . As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into designated waste container. 3. During an observation conducted in the COVID 19 Positive Isolation Unit (Unit 418), on 8/5/20 at 12:30 PM, the exit door area designated for removal of all PPEs did not have hand washing sink or ABHR available for sanitizing staff hands immediately after removal of all PPEs. During a concurrent interview with the NC, he confirmed there was no hand washing sink or ABHR in the area. He stated ABHR should be available upon removal of all PPEs. A review of the facility policy dated 4/9/20, titled, .COVID 19 NURSING PROTOCOL: DOFFING (REMOVING) PPE, indicated, .Wash hands or use an alcohol-based hand sanitizer immediately after removing all PPE.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.