STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555330	A. BUILDING _____ B. WING _____	**07/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERSIDE POSTACUTE CARE	**8781 LAKEVIEW AVENUE RIVERSIDE, CA 92509**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement proper infection control practices in preventing the transmission of the [MEDICAL CONDITION] infection (COVID-19 - virus causing respiratory symptoms), when: 1. A facility staff entered the Green zone unit (unit for the resident negative of COVID 19 virus and was not exposed to a person with confirmed COVID-19 virus) wearing the PPE he used while at the yellow zone unit (unit for resident that had an exposure to a person with confirmed COVID 19 virus, and has an unknown COVID 19 status); 2. An Occupational Therapist (OT) was wearing personal protective equipment (PPE-equipment worn by an individual for protection against infectious material) such as face mask, face shield, gloves, and isolation gown, while outside the facility; and 3. The facility staff were using the same isolation gown in providing care to multiple residents in the yellow zone unit. These failures had the potential to result in the spread of COVID-19 infection to residents and staff. Findings: 1. On July 17, 2020, at 11:10 a.m., the Director of Staff Development (DSD) was interviewed. She stated the facility nursing unit were divided into three zones, namely: Red zone unit (for residents with confirmed test result of COVID-19 virus), the Yellow zone unit, and the Green zone unit. The DSD stated the staff should use the designated entrance and exit when crossing a specific unit. She stated the staff should be donning (putting on) or doffing (removing) the required PPE prior to entering or exiting each unit. On July 17, 2020, at 11:15 a.m., a Certified Nursing Assistant (CNA) was observed entering the Yellow zone unit through the partition curtain, and was wearing a face mask, face shield, and yellow (isolation) gown. In a concurrent interview, the CNA stated he went to the kitchen located in the Green zone unit (non COVID-19 unit) without removing the PPEs he used while at the Yellow zone unit. He stated he was aware that the staff should not be crossing units through the partition curtain. The CNA stated the staff should use the designated entrance and exit for proper donning and doffing of PPEs. 2. On July 17, 2020, at 11:34 a.m., during the facility tour with the DSD, a staff (OT) was observed outside the facility wearing a face mask, face shields, gloves, and yellow gown. In a concurrent interview, the OT stated he should have removed his PPEs prior to stepping outside the facility. 3. On July 17, 2020, at 12:16 p.m., during the facility tour conducted with the DSD, at the Yellow zone unit, a licensed nurse wearing PPEs (face mask, face shield, and yellow gown) was observed coming out of a resident's room. The licensed nurse removed her gloves, performed hand hygiene and proceeded to another resident's room, without removing the yellow gown. The DSD stated the staff assigned to work at the Yellow zone unit were required to wear the following PPEs: face mask, face shield and yellow gown. She stated the staff would wear the same yellow gown in providing care to multiple residents with unknown COVID 19 status throughout the entire shift. On July 17, 2020, at 4:22 p.m., the Director of Nursing (DON) was interviewed. The DON stated the Yellow zone unit was designated for the residents that had an exposure to a person with confirmed COVID-19 virus or for newly admitted residents that needed monitoring because of their unknown COVID 19 status. The DON stated she was aware that the facility staff uses the same yellow gown when providing direct patient care to multiple residents who were under investigation due to unknown COVID 19 status. She stated using the same yellow gown during provision of care to multiple residents had the potential of spreading [MEDICAL CONDITION]. A review of the web article from the Centers for Disease Control and Prevention (CDC) titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic, updated July 15, 2020, .Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection . The PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following .Gowns .Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use . A review of the web article from the CDC titled, Preparing for COVID-19 in Nursing Homes, updated June 25, 2020, .If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections . A review of the facility's policy and procedure (P&P) titled, Interim Infection Prevention and Control for COVID-19 Infection, with a release date of May 19, 2020, indicated, .Patient Placement and Resident Care . For resident with possible exposure to COVID-19 (Yellow Zone) . Place resident in designated yellow zone. HCP: Follow CDC guideline on PPE use: Facemask, gown, gloves . For resident with no exposure to COVID-19 and with negative COVID-19 PCR test (Green Zone) . Place resident in designated green zone. HCP PPE: Facemask and gloves . The facility's P&P titled, Personal Protective Equipment - Using Gowns, with a release date of January 2018, indicated, .Use gowns only once and then discard into an appropriate receptacle inside the exam or treatment room .When use of gown is indicated, all personnel must put on the gown before treating or touching the resident .After completing the treatment or procedure, gowns must be discarded in the appropriate container located in the room .Soiled gowns must not be worn in break rooms, lobbies, or into any area in which contamination of equipment is likely to occur .

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