STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555748	A. BUILDING _____ B. WING _____	10/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BERKLEY EAST CONVALESCENT HOSP	**2021 ARIZONA AVE SANTA MONICA, CA 90404**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, Certified Nursing Assistant 1 (CNA 1) failed to perform hand hygiene on multiple occasions when assisting 2 of 3 sampled residents (Resident 1 and Resident 2): 1.Prior to and after assisting Resident 1 and Resident 2. 2.Prior to donning and removing of gloves when assisting Resident 1. This deficient practice had the potential to spread infection. Findings: On 8/18/20, at 4:55 p.m., an unannounced visit was made to the facility to conduct a COVID-19 Coronavirus 19 ((COVID-19) a new illness that can affect your lungs and airways) focused survey. Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. She was transferred to the general acute care hospital on [DATE] for abdominal pain, nausea and vomiting. During an observation and concurrent interview with Resident 1 in his room in the green zone on the third floor of the facility, on 8/18/20, at 6:44 p.m., Resident 1 pressed the call light button. During an observation and concurrent interview with Resident 1 in his room in the green zone on the third floor of the facility, on 8/18/20, at 6:47 p.m., CNA1 entered Resident 1's room in response to Resident 1's call light request. CNA 1 did not perform hygiene upon entering Resident 1's room. Observed hand sanitizer and box of gloves inside of Resident 1's room at the door entrance mounted on the right side of the wall. CNA 1 turned off the call light button on the wall of the room. He did not perform hand hygiene. Resident 1 requested coffee and for CNA 1 to pick up paper trash that was on his room floor. CNA 1 donned gloves without performing hand hygiene prior to donning the gloves. CNA 1 picked up the paper trash on the floor, opened the bathroom door, discarded the paper trash, and closed the bathroom door while wearing the gloves. CNA 1 removed his gloves. CNA 1 did not perform hand hygiene after removing his gloves. CNA 1 picked up Resident 1's coffee cup and exited Resident 1's room without performing hand hygiene. CNA 1 walked to the nursing station with Resident 1's coffee cup in his right hand and touched the nursing station with both hands. CNA 1 spoke to the staff member at the nursing station desk and requested for housekeeping to clean Resident 1's floor. Observed CNA 1 walk to the coffee dispenser in the dining room located on the 3rd floor and began to fill Resident 1's coffee cup with coffee without performing hand hygiene. During a concurrent interview with CNA 1 in the dining room area on the third floor of the facility, on 8/18/20, at 6:53 p.m., CNA 1 acknowledged that he did not perform hand hygiene on multiple occasions when working with Resident 1. He stated that he should have performed hand hygiene to prevent the spread of infection. During an observation and concurrent interview with Resident 2 in his room in the green zone on the third floor of the facility, on 8/18/20, at 7:09 p.m., Resident 2 pressed the call light button. During an observation and concurrent interview with Resident 2 in his room in the green zone on the third floor of the facility, on 8/18/20, at 7:12 p.m., CNA1 entered Resident 2's room in response to Resident 2's call light request. CNA 1 did not perform hygiene upon entering Resident 2's room. Observed hand sanitizer and box of gloves inside of Resident 2's room at the door entrance mounted on the right side of the wall. Resident 2 requested for CNA 1 to turn his television volume down. CNA 1 turned Resident 2's television volume down using the nurse call light and volume controller device without performing hand hygiene. CNA 1 began to exit Resident 2's room without performing hand hygiene. During a concurrent interview with CNA 1 at the entrance of Resident 2's room, in the green zone on the third floor of the facility, on 8/18/20, at 7:15 p.m., CNA 1 acknowledged that he did not perform hand hygiene despite being interviewed earlier about not performing hand hygiene while working with Resident 1. He stated and confirmed that he should have performed hand hygiene to prevent the spread of infection. He performed hand hygiene using the hand sanitizer inside of Resident 2's room. After performing hand hygiene, CNA1 inquired surveyor if that was sufficient. During an interview with the Director of Nursing (DON), Infection Preventionist (IP), and Registered Nurse 1 (RN 1), on 8/18/20, at 9 p.m., DON, IP and RN 1 acknowledged and confirmed that CNA 1 should have performed hand hygiene before and after all resident contact, when providing care, and when putting on or taking off gloves, to prevent the spread of infection. A review of the facility's policy and procedures titled Infection Prevention and Control: Novel Coronavirus (COVID-19), revised date 9/15/20, indicated it is the policy of the facility to adhere to standard precautions. Personal Protective Equipment (PPE) includes: gloves. Hand hygiene using alcohol based hand rub/sanitizer before and after all resident contact, and before and after removal of PPE, including gloves. A review of the facility's policy and procedures titled Handwashing/Hand Hygiene, dated 2001, revised date 9/2015, indicated the facility considers hand hygiene the primary means to prevent the spread of infections. Policy interpretation and implementation: 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. 7. Use an alcohol-based hand rub for the following situations: b. before and after direct contact with residents, m. after removing gloves. o. before and after handling food. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment.

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.