STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056466	A. BUILDING _____ B. WING _____	**09/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIERRA VIEW CARE CENTER	**14318 OHIO STREET BALDWIN PARK, CA 91706**

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 provide a safe, sanitary environment to help prevent the spread of infections during the Coronavirus-19 (COVID-19, a respiratory illness that can spread from person to person) as indicated in the facility's policy and procedure by failing to: 1. Ensure to disinfect and dispose of personal protective equipment (PPE) according to current guidelines. 2. Ensure staff wore the appropriate PPE in the red zone (an area where residents who test positive for CoVID-19 disease are confined). 3. Ensure a designated PPE doffing (remove) area in the red zone was in place. These deficient practices had the potential to spread infections to other residents, staff, and visitors. Findings: During an observation on 7/9/20 at 12: 30 PM, several staff walked from the yellow zone hallway to exit from the front entrance to the parking lot with the N95 mask (is a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) and face shield. During an interview with the Licensed Vocational Nurse 1 (LVN 1), stated he removed his N95 and face shield outside the front lobby and placed them in the plastic bag. LVN 1 did not answer when asked if he disinfected his face shield before placing in the plastic bag or brown bag. During an observation and concurrent interview with the Infection Preventionist (IP) on 7/9/20, at 12:45 PM, IP stated staffs removed their N95 masks, face shields in their car, take them home, and bring them back for reuse. The IP stated she was not sure how the staffs disinfect their N95 masks and face shields. During an observation and concurrent interview with the IP on 7/9/20, at 12:50 PM, stated the staff used N95 and face shield in yellow zone (an area/unit for residents that are symptomatic, had closed contact or exposure to the resident confirmed COVID 19 positive, and [MEDICAL TREATMENT] residents under observation for symptoms of COVID 19). The IP stated the staff doff (remove) their N95 and face shield outside the front entrance. The IP stated, the trash bin for yellow zone located outside the main entrance door did not have a PPE doffing poster. The IP stated, there were no alcohol-based hand rub (ABHR) nor hand washing sink for the staff to use after removing their N95 masks and face shield at the end of their shift. During an observation and interview with Licensed Vocational Nurse 3 (LVN 3) on 7/9/20, at 3:05 PM, in the red zone (area/unit of residents with confirmed COVID 19 positive), she stated she used a white laboratory gown, hang it by the door in the breakroom during break and reused throughout the shift. LVN 3 stated she took her white gown, N95, and face shield home and brought it back to reuse. During observation and interview with LVN 3 on 7/9/20, at 3:08 PM, LVN 3 stated she removed her N95 mask and face shield because she was in the doorway of the breakroom. During concurrent interview with the IP, she stated LVN 3 would need to wear the N95 mask and face shield at all times in the red zone. During an observation and interview with Certified Nursing Assistant 2 (CNA 2) on 7/9/20, at 2:50 PM, she stated she did not wear her face shield nor eye shield in the red zone because she forgot to bring her eye shield to work. During concurrent interview with the IP, she stated CNA 2 would need to wear her face shield or eye shield at all times in the red zone. During an observation and concurrent interview with the IP on 7/9/20, at 3:25 PM, she stated the red zone did not have a separate PPE donning and doffing area. The IP stated, there were no separate trash bins nor ABHR or hand-washing sink for doffing PPE. The IP stated the facility would set up a separate PPE doffing area to prevent cross contamination. A review of the facility policy and procedure titled, undated Infection Control Manual, indicated staff would use appropriate PPE when they interacted with residents, to the extent PPE was available and per CDC guidance on conservation of PPE. The policy indicated full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE. The policy indicated that reusable eye protection would be cleaned and disinfected according to the manufacturer's recommendation and disposable eye protection would be discarded after use.

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