STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555200	A. BUILDING _____ B. WING _____	**07/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY WEST POST ACUTE	**1224 E STREET WILLIAMS, CA 95987**

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 maintain an effective infection prevention and control program to help prevent the development and transmission of COVID-19 between residents, when two of three sampled residents (Residents 2 and Resident 3) were cared for by the same staff as a known COVID-19 positive resident (Resident 1). This failure had the potential for cross-infection of COVID-19 from Resident 1 to Residents 2, and Resident 3, who were in observation and whose COVID-19 status unknown. Findings: The facility's COVID-19 Mitigation Plan was reviewed and indicated, that resident care staff would be assigned to work in the red zone (an area designated for isolation of confirmed positive, and symptomatic suspected COVID-19 residents) exclusively to the extent possible. Resident 1's medical record was reviewed, and indicated they were admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 1's record contained documentation that the resident had tested positive for COVID-19 on 7/7/20, including a Social Services Note dated 7/8/20 that read On 7/7/2020 @ 2209 hrs (at 10:09 pm) SSD (Social Services Director) was able to contact wife/RP (responsible party). Wife/RP was informed of resident being positive for COVID-19. There was an additional Social Services Progress Note dated 7/6/20 that read Room change: Resident was moved from room xxx to xxx (room with the facility's red zone) on 7/4/20 due to having some symptoms. There was a physician's orders [REDACTED]. A vital signs record for Resident 1 indicated elevated temperatures over 100 degrees Fahrenheit on the dates of 7/4 and 7/5/20. A Licensed Nurse Progress Note dated 7/9/20 for Resident 1 indicated the resident had a slight cough. Under Infection there was documentation that Resident 1 was in a single room isolation for aiborne precautions. Resident on airbornd isolation r/t (related to) COVID-19 test positive. Under Mood & Behavior there was documentation of 0 s/sx (no signs or symptoms) of depression r/t new Dx (diagnosis). Resident 2's medical record was reviewed, and indicated they were admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident 2 had left the facility, and returned from an appointment on 7/6/20, and was placed in observation in the facility's designated yellow zone (room [ROOM NUMBER], an area designated for those residents awaiting COVID-19 test results with no symptoms, exposed residents to COVID-19, and newly admitted residents). Resident 3's medical record was reviewed, and indicated they were admitted to the facility on [DATE], and readmitted on [DATE], with [DIAGNOSES REDACTED]. Resident 3 had returned from an acute hospital stay on 7/3/20, and was placed in observation in the facility's designated yellow zone (room [ROOM NUMBER]). A Review of the facility's, Census and Hours, (daily staff assignment sheet), dated 7/9/20, indicated that Licensed Nurse (LN) B and Certified Nurse Assistant (CNA) C were assigned to ISO (isolation) for the 6 am to 2:30 pm shift. During an interview, on 7/9/20 at 11:35 am, with the Administrator (Admin), he confirmed that staff for the facility's designated red and yellow zones, were assigned and caring for residents in both zones. During an interview on 7/9/20 at 11:55 am with the DON (Director of Nursing), the DON indicted that on that day (7/9/20) the staffing was way over. The DON described the process the facility would use if they needed to obtain additional staff and the DON again stated that they were over staffed. During an interview, on 7/9/20 at 12:46 pm with Infection Preventionist (IP), she stated that resident care staff should not be assigned care for residents in both the red and yellow zones. The IP indicated that each area should have staff assigned separately to prevent cross-infection between residents. During an observation, and concurrent interview, on 7/9/20 at 2 pm with LN B, she was observed to be caring for residents in both the designated red (room [ROOM NUMBER]), and yellow zones (Rooms 102 & 104). LN B stated she was assigned to and caring for Resident 1 (red zone), and Residents 2 and 3 (yellow zone). During an observation and concurrent interview, on 7/9/20 at 2:05 pm with CNA C, she was observed to be caring for residents in both the designated red and yellow zones. CNA C stated she was assigned to and caring for Residents 1, 2 and 3. During the exit conference interview on 7/9/20 at 2:55 pm with the facility Administrator, DON, ADON (Assitant DON), SSD and IP in attendance, it was confirmed that staffing was not an issue on 7/9/20. A review of the Centers for Disease Control and Prevention guidance, Preparing for COVID-19 in Nursing Homes, updated 6/25/20, indicated in the section titled, Resident Cohorting, to Assign dedicated HCP (Health Care Personnel) to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for the residents.

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