| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055147 | A. BUILDING _____ B. WING _____ | 07/15/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **MADERA REHABILITATION & NURSING CENTER** | **517 SOUTH A STREET MADERA, CA 93638** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to implement and maintain a safe environment with an effective infection prevention and control program for the prevention of [MEDICAL CONDITION] (COVID-19- a contagious serious respiratory infection transmitted from person to person) transmission when: 1. The Administrator (ADM), in an attempt to search for his dedicated (intended for one person) N-95 respirator (respiratory protective device designed to achieve a very close facial fit and very filtration of airborne particles), searched through a storage bin and touched bags that contained other staff's dedicated N-95 respirator; 2. The ADM did not wash his hands before and after he applied his N-95 respirator; 3. Staff's N-95 respirator were stored in a paper bag that was inside of a sealed plastic bag; and 4. The ADM did not disinfect (the process of cleaning something, especially with a chemical, in order to destroy bacteria) an area of a table where he had placed his personal facemask (a protective mask covering the nose and mouth). These practices potentially placed the residents and staff at risk for the spread and transmission of COVID-19, complications from COVID -19 and death. Findings: 1. During an observation on 7/15/20 at 8:55 a.m., in the lobby of the facility, the personal protective equipment (PPE- equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) storage area was observed. There were several large storage bins with signs that indicated various staff classifications on the bins. The bins contained paper bags and plastic bags. The plastic bags contained the paper bag. Some of the plastic bags were opened and others were sealed via a zip lock (having an interlocking groove and ridge that form a tight seal) mechanism. The ADM entered the facility during this observation and walked over to one of the storage bins and with both of his hands, started going through the storage bin, touching the plastic and paper bags that contained the staff's dedicated respirator. The ADM withdrew a paper bag from the storage bin, looked at it, realized it was not his respirator, and placed it back in the storage bin. The ADM then went to another storage bin and found his designated respirator. During an interview on 7/15/20 at 12:50 p.m., with the Infection Prevention Nurse (IPN), the IPN stated the PPE storage system is not ideal and the facility is still looking for a better way to store PPE. The observation of staff touching multiple bags before finding their own PPE in the storage bin was described. The IPN stated staff touching multiple bags that contained dedicated PPE before finding their own PPE was not the best, and was a potential for cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). The IPN stated We will find a better way to store the N-95 (respirator) to make sure that there is a separation between staff's N-95 (respirator). A policy and policy for PPE storage and re-use (use again or more than once) was requested. The facility was unable to provide a policy or procedure prior to the exit of the survey. 2. During an observation on 7/15/20 at 8:55 a.m., in the lobby of the facility, the ADM entered the facility and walked to the dedicated PPE area. The ADM stood in front of one of the storage bins and with both of his hands, started going through the storage bin, touching the plastic and paper bags. The ADM withdrew a paper bag from the storage bin, looked at it, realized it was not his respirator, and placed it back in the storage bin. The ADM then went to another storage bin and found his designated respirator. The ADM did not wash his hands. The ADM used his left hand to remove his cloth mask that was on his face, placed both of his hands on the outside of his dedicated N-95 respirator, and touched the inside of his N-95 respirator with both his fingers while applying the N-95 respirator to his face. Without washing his hands, the ADM escorted the survey team to a multipurpose room. During an interview on 7/15/20 at 12:50 p.m., with the Nurse Consultant (NC), the NC stated employees needed to wash their hands after removing a mask and prior to placing a mask on. During a review of the facility's policy and procedure (P&P) titled, Personal Protective Equipment - Using Face Masks, dated September 2010, the P&P indicated, .Objectives .1. To prevent transmission of infectious agents through the air .3. To prevent transmission of some infections that are spread by direct contact with mucous membranes .Miscellaneous .5. Before changing a face mask, wash hands .8. Handle mask only by the strings (ties). 10. Follow established handwashing techniques .Procedure Guidelines .4. Unfold the mask. Do not touch the part of the mask that will cover the face. Hold the mask by the strings only .Removing the mask 1. Wash Hands .Untie the lower strings of the mask first. Hold the strings of the mask only. 3. Untie the top strings of the mask. Remove the mask from the face. Handle strings only. 4. Discard the mask into the designated waste receptacle .5. Wash hands . 3. During an observation on 7/15/20 at 8:55 a.m., in the lobby of the facility, the PPE storage area was observed. There were several large storage bins with signs that indicated various staff classifications on the bins. The bins contained paper bags and plastic bags. The plastic bags contained the paper bag. Some of the plastic bags were opened and others were sealed via a zip lock mechanism. During an interview at 7/15/20 at 9:08 a.m., with the ADM, the ADM stated the staff's personal respirators were placed in paper bags and some were sealed in plastic bags. The ADM stated plastic bags that contained the paper bag should not be sealed and should have been opened. During a professional reference review, retrieved on 7/27/20, from https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html dated 6/28/20, titled, Strategies for Optimizing the Supply of Facemasks indicated, .This document offers a series of strategies or options to optimize supplies of facemasks in healthcare settings when there is a limited supply .Crisis Capacity Strategies .Implement limited re-use of facemasks .HCP (health care providers) should .The folded mask can be stored between uses in a clean sealable paper bag or breathable container . 4. During an observation on 7/15/20 at 8:55 a.m., in the lobby of the facility, the ADM entered the facility and walked over to one of the storage bins and with both of his hands, started going through the storage bin, touching the plastic and paper bags. The ADM withdrew a paper bag from the storage bin, looked at it, realized it was not his respirator, and placed it back in the storage bin. The ADM then went to another storage bin and found his designated respirator. The ADM did not wash his hands. The ADM used his left hand to remove his cloth mask that was on his face, placed both of his hands on the outside of his dedicated N-95 respirator, and touched the inside of his N-95 respirator with both his fingers while applying the N-95 respirator to his face. Without washing his hands, the ADM escorted the survey team to a multipurpose room and placed his cloth mask, with the section that was directly against his nose minutes earlier, directly on the table. A few minutes later, the ADM picked up his cloth mask and left the multipurpose room without sanitizing the surface of the table that his mask touched. During an interview on 7/15/20 at 12:50 p.m., with the IPN, the process for surface cleaning was discussed. The situation with a cloth mask placed on a table was described. The IPN stated she educated staff on the process of surface disinfecting which included .Disinfecting with bleach, wipe the area with bleach and leave it wet for 5 minutes and air dry . The IPN stated if PPE touched a surface, the surface should be disinfected. During a review of the facility's P&P titled Cleaning and Disinfection of Environmental Surfaces, dated June 2009, the P&P indicated, Policy Statement - Environmental surfaces will be cleaned and disinfected according to current CDC (Center for Disease Control) recommendations for disinfection of healthcare facilities 1 c. Non-critical items are those that come in contact with intact skin but not mucous membranes. (1) Non-critical environmental surfaces include bed rails, some food utensils, beside tables, furniture and floors .2. Non critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use |

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.

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