STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056477	A. BUILDING _____ B. WING _____	07/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EASTLAND SUBACUTE AND REHABILITATION CENTER	3825 DURFEE AVE EL MONTE, CA 91732

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 follow infection control and prevention guidelines by failing to: 1. Ensure signage was posted immediately outside of 12 of 12 resident rooms indicating the appropriate infection control and prevention precautions in the yellow zone (the area designated for residents exposed to Covid-19, readmitted residents who are pending test results for Covid-19 and symptomatic residents with undetermined test results)/PUI (Person Under Investigation) unit. 2. Ensure the facility had a donning (putting on PPE-personal protection equipment-protects the wearer from contamination of infectious matter)/doffing (removing PPE) station and that the necessary PPE was immediately available outside of 9 of 12 resident rooms in the yellow zone/PUI unit. 3. Ensure the facility's staff don the required PPE prior to entering the resident's room in the yellow zone. 4. Ensure trash disposal bins were placed inside of 12 of 12 resident rooms in the yellow zone/PUI unit so that staff would be able to discard their PPE prior to exiting the resident's room in the yellow zone/PUI unit. These deficient practices may potentially lead to the spread of Covid-19 to other residents and staff. Findings: On 7/13/20, at 3:19 p.m., an unannounced Covid-19 Focused Survey for Nursing Homes and a Quality, Safety, and Oversight survey was conducted at the facility. During a tour to the yellow zone area, accompanied by the Director of Nursing (DON) and the facility's designated Infection Preventionist (IP, nurse who helps prevent and identify the spread of infectious agents like bacteria [MEDICAL CONDITION] in a healthcare environment) the following were observed: a. No signage was observed indicating the yellow zone/PUI unit was an isolation area (separation and confinement of those known or suspected to be infected with a contagious disease agent to prevent further infections). b. No signage was posted outside the 12 resident rooms that indicated the type of isolation the residents were on. c. No signage was posted indicating: hand washing/hand sanitizing procedures and PPE donning and doffing procedures. d. The unit consists of 12 rooms, however, only three rooms (102, 103, and 111) had PPE carts/donning stations outside of the rooms. On 7/13/20, at 3:34 p.m., during a concurrent observation and interview, Certified Nursing Assistant 1 (CNA 1) exited a yellow/PUI room, wearing a surgical mask, face shield, gloves, and a blue disposable gown. CNA 1 doff the disposable gown and the gloves outside the room, in the hallway and placed them in a trash container in the hallway. CNA 1 then entered room [ROOM NUMBER] (in the yellow/PUI unit), wearing a white reusable gown, surgical mask, face shield, and gloves. CNA 1 was not wearing a blue/disposable gown. CNA 1 provided care to the resident in the room and exited room [ROOM NUMBER] and sanitized her hands. CNA 1 stated, she just finished changing the resident's soiled adult briefs. CNA 1 stated, she wore the white/reusable gown for two hours and cares for other residents wearing the same gown before changing it. CNA 1 stated, the facility practice was to wear a blue disposable gown prior to providing direct care in the yellow/PUI room and remove the disposal gown it in the room, prior to exiting the room. CNA 1 stated, she had forgot to wear the blue disposable gown and it was important to wear it to protect themselves and the residents. On 7/13/20, at 3:38 p.m., during a concurrent observation and interview, CNA 2 and 3 where in room [ROOM NUMBER] (in the yellow/PUI unit) changing the resident's soiled diaper. They were wearing white/reusable gowns, gloves, face shield, and surgical masks. They were not wearing a disposable blue gown. After providing care CNA 2 and 3 went to room [ROOM NUMBER] and were observer donning a blue disposable gown. CNA 2 and 3 stated, they just finished changing a soiled adult brief for the resident in room [ROOM NUMBER] and were about to enter room [ROOM NUMBER]. When asked the reason they were donning a blue disposable gown, they stated, it was because the resident in room [ROOM NUMBER] had some type of infection and there was a PPE cart in front of the room. When asked the reason a blue disposable gown was not worn for room [ROOM NUMBER], they stated, because the room did not have a PPE cart, PPE donning station and no signage indicating isolation in front of the room. Which meant the resident in room [ROOM NUMBER], did not have any isolation that required the use of a disposable gown. CNA 2 stated, they have not been told to wear a disposable gown for every resident in this unit. The rooms that do not have a PPE cart outside the room and a donning stations do not require them to wear a disposable gown. Only the ones with a PPE cart outside the room. The CNAs did not know what kind of isolation the resident in room [ROOM NUMBER] had because there were no signs indicating the type of isolation precaution required. On 7/13/20, at 4 p.m., during an observation and concurrent interview, Licensed Vocational Nurse 1 (LVN 1) stated, this unit was for residents with undetermined Covid-19 infection status. The isolation precautions for this unit are contact (used for infections, diseases, or germs that are spread by touching the resident or items in the room) and droplet (used for diseases or germs that are spread in tiny droplets caused by coughing and sneezing) precautions. LVN 1 stated, the nurses have to wear a disposable gown, over the white reusable gown prior to providing direct patient care, such as changing soiled briefs. LVN 1 verified there were no signs by the residents rooms indicating droplet and contact precautions. Only some of the resident's rooms had a PPE carts in front of the their room. There were no trash cans in the rooms to discard used PPE (gowns). LVN 1 stated, the nurses have to doff their disposable gown prior to exiting the resident's room and verified the rooms had no trash cans to dispose the used PPE into. On 7/13/20, at 4:30 p.m., during an interview, Licensed Vocational Nurse 2 (LVN 2) stated, it was the facility practice to don a disposable gown over the reusable gown, prior to entering the residents' room and doff the disposable gown prior to exiting the room. However, because there were no trash cans for PPE in the residents' rooms, the staff doff the PPE outside their residents rooms and disposed of them in the trash can located in the hallway. A review of the facility's policy and procedures titled, Covid-19 Facility Infection Prevention Quality Control Plan, revised 5/26/20, indicated, the facility would post visual alerts (signs, posters) at entrances and in strategic places providing instruction on hand hygiene, respiratory hygiene, and cough etiquette, the facility would use PPE based on CDC (Communicable Disease Control) and Public Health guidance. A review of the facility's, Mitigation Plan (MP), dated 6/29/20, indicated: Signs are posted immediately outside of the resident rooms indicating appropriate infection control and prevention precautions and required PPE in accordance with CDPH (California Department of Public Health) guidance. Necessary PPE was to be immediately available outside of the resident's room when there are units with separate cohorted spaces for both Covid-19 positive and negative residents or in the corridor near rooms in dedicated Covid-19 units and in other areas where resident care is provided. Trash disposal bins are positioned as near as possible to the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room. A review of the facility's policy and procedure, Covid-19 for designation of space, revised 5/26/20, indicated infection control procedures including administrative rules and engineering controls, environmental hygiene, correct work practices, and appropriate use of PPE all are necessary to prevent infections from spreading during healthcare delivery, designate a clean and dirty area within the unit, clean area is where you wear and change your PPE, dirty area is where you don-off your PPE and collect reusable PPE for disinfection.

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.