STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055223	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAN JACINTO HEALTHCARE	**275 NORTH SAN JACINTO STREET HEMET, CA 92543**

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 implement proper infection control practices in preventing the transmission of the [MEDICAL CONDITION] infection (COVID 19- virus causing respiratory symptoms), when: 1. There was no sign posted outside the room to indicate the appropriate infection control and prevention precautions and the required personal protective equipment (PPE- equipment worn by an individual for protection against infectious material) in providing care for the resident with unknown COVID 19 status (Resident 1). In addition, the necessary PPEs were not readily available outside the resident's room; 2. A resident (Resident 2) was not cohorted (grouped together) in the appropriate designated area as soon as the laboratory result was confirmed of COVID 19 virus; and 3. A facility staff (Certified Nursing Assistant/CNA) went out of the COVID 19 unit, to go to her car, wearing an isolation gown. These failures had the potential to result in the spread of COVID 19 infection to the residents and staff. Findings: 1. On August 18, 2020, at 10:57 a.m., an interview was conducted with the Quality Assurance Nurse (QAN). She stated Resident 1 was transferred to the PUI (person under investigation) unit (unit for residents exposed to a suspected or laboratory confirmed case of COVID 19, and with unknown COVID 19 status) pending COVID-19 test result. On August 18, 2020, at 11:40 a.m., during an observation of Resident 1's room with the charge nurse (CN), there was no sign posted by the resident's room to indicate the infection control and prevention precautions and the required PPE for providing care to Resident 1. There was no isolation cart containing PPE outside the resident's room. In a concurrent interview with the CN, she stated there should have been a sign indicating the appropriate isolation precaution by the door of the resident's room, as soon as the resident (Resident 1) was moved on isolation. A review of the facility policy and procedure (P & P) titled, Infection Control Patient Care during COVID 19- Pandemic, dated May 6, 2020, .Person Under Investigation (PUI) .Patients who are exposed to patients and staff tested positive are placed under PUI unit .Personal Protective Equipment (PPE) Appropriate PPE must be worn at all times during patient care, medication administration, housekeeping and restorative nursing activity .PPE requirements signage are visibly posted on the dedicated entrance door. PPE requirements for PUI include gloves, gown, (N95) mask, and face shield .PPE supplies are replenished by a dedicated HCP (healthcare care personnel) and visibly placed inside a dedicated linen cart . 2. On August 18, 2020, at 10:57 a.m., during the facility tour, with the Quality Assurance Nurse (QAN), at the green zone (non-COVID 19 area), the resident's (Resident 2) room was observed with a sign indicating an isolation precaution (to prevent the spread of infection in the health care setting) and a cart containing PPEs. In a concurrent interview with the QAN, she stated Resident 2 was positive of COVID 19 virus. On August 18, 2020, at 2:15 p.m., Resident 2's record was reviewed with the Clinical Coordinator (CC). Resident 2 was readmitted to the facility on [DATE]. The resident's COVID 19 laboratory results report indicated, .Collection Date: 08/14/2020 .Received Date: 08/15/2020 .Reported Date: 08/17/2020 20:12 (8:12 p.m.) .COVID 19 Result .Detected . The CC stated the laboratory result report indicated the nurse reviewed the result on August 18, 2020, at 8:09 a.m. (12 hours since the test was documented as reported), and Resident 2 was placed on isolation. She stated the charge nurse assigned during the night shift (10:30 p.m. to 7 a.m.) should have checked the laboratory result last night (August 17, 2020) for Resident 2. In addition, she stated the resident (Resident 2) should have been on isolation precaution for COVID-19 since last night, to prevent spread of [MEDICAL CONDITION]. A review of the facility policy and procedure titled, Infection Control Patient Care during COVID-19 Pandemic, dated May 6, 2020, indicated, .In addition to standard precautions, patients suspected or infected with COVID-19 infections will be segregated in specific cluster of rooms in the building to contain spread of COVID-19 infection among residents and minimize [MEDICAL CONDITION] exposure to residents and health care personnel (HCP) . 3. On August 18, 2020, at 12:05 p.m., during the tour with the Quality Assurance Nurse (QAN) and the Clinical Coordinator (CC), outside the designated entrance of the COVID 19 unit, a staff (CNA) was observed going out of the unit wearing a disposable black gown. The CNA was observed going inside her car and going back to the COVID 19 unit, wearing the same disposable gown. On August 18, 2020, at 12:10 p.m., an interview was conducted with the CNA. The CNA stated she was aware that she was wearing an isolation gown when she went out of the COVID 19 unit, to go to her car, and when she came back inside of the COVID 19 unit. The CNA knew she had to remove her gown prior to leaving the unit. A review of the facility policy and procedure titled, Infection Control Patient Care during COVID 19 Pandemic, dated May 6, 2020, indicated, .COVID 19 Positive (RED UNIT) .Personal Protective Equipment (PPE) .When staff is ready to exit COVID 19- Unit, PPEs including gowns shall be doffed at the end of the hallway closed to the exit .

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