STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055519	A. BUILDING _____ B. WING _____	**06/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DOWNEY POST ACUTE	**13007 S. PARAMOUNT BLVD. DOWNEY, CA 90242**

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** - Potential for minimal harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to provide a sanitary environment and to help prevent the development and transmission of communicable diseases and infections, when one of one laundry staff (Laundry aid 1) placed two protective gowns, used as personal protective equipment ((PPE) protective clothing, goggles, or other garments or equipment designed to protect the wearer's or the resident from infections) to sort soiled laundry, over a clean blanket, covering a basket used to transport the clean laundry. This deficient practice had the potential to cause cross contamination from the soiled PPE gowns to the clean blanket, when Laundry aid 1 placed two soiled PPEs on a clean blanket covering a basket used to transport clean laundry to the residents. Findings: During an observation of the laundry room on 6/22/20 at 2 p.m., there were two green gowns lying on a clean laundered blanket, which was covering an empty basket used to transport clean laundry to the residents. During interview Laundry Aid 1 stated the gowns were supposed to be worn when sorting soiled or contaminated laundry. When asked if the green gowns (lying on the blanket) were clean or soiled, Laundry Aid 1 stated they should be clean. The laundry/housekeeping supervisor (LHS), who was also present during the observation, stated the gowns should be thrown away because it was not clear whether the gowns were clean or soiled. LHS stated the gowns should have been hung up on a hook after use but since it was not clear if they were clean or soiled, chose to dispose the gowns. During a concurrent interview and record review on 6/22/20 at 3:20 p.m., the Infection Preventionist ((IP) reports to the Director of Nursing and partners with the Medical Director, the Administrator, and others to develop a system of care that promotes sound and scientific infection prevention principles and practices) reviewed inservice rosters and competency checklists for the laundry staff. When asked if Laundry aid 1 had received inservices or training on infection control measures, IP looked through the sign-in sheets and stated, It doesn't look like she attended the inservices. Then IP stated, I will make sure she is trained and provided with inservices. A review of the facility's policy and procedure titled Emerging infectious Disease Emergency & Quality Control Plan Coronavirus 2019 (COVID-2019), dated 3/20, indicated the facility would provide education and job-specific training to staff regarding COVID-19 including: correct infection control practices and personal protective equipment (PPE) use. A review of the facility's policy and procedure titled Infection Control Prevention and Control Program, revised 9/2017, indicated the goals of the infection control program were to decrease the risk of infection to residents and personnel, identify and correct problems relating to infection control practices, ensure compliance with state and federal regulation relating to infection control, and monitor employee health and safety.
F 0921 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation, interviews, and record review, the facility failed to maintain laundry equipment used for washing the resident's linen and clothing, in a sanitary, working order. There were puddles of water on the floor behind two of two washers, floor drain was not draining, and water was pooling underneath boxes of detergent/chemicals used for laundry. This deficient practice had the potential to cause cross contamination of germs and growth of bacteria from water sitting on the floor and underneath boxes of chemicals. Findings: During an observation of the laundry room on 6/22/20 at 2 p.m., there were puddles of water behind each washing machine. When asked LHS stated the drain on the floor had been plugged several days earlier, but it had been fixed. LHS stated he did not know why there were water pooled on the floor, behind the washing machines. During the same time, there was water on the floor, across the room, underneath the bottles of sanitizing solution used to disinfect laundry. There was water underneath two of 13 boxes of chemical laundry sanitizers, which were sitting on the floor. LHS stated the boxes should not have been placed on the floor. LHS stated, I gotta get a pallet to put them on. When asked what could happen since the bottom of the two boxes were wet, LHS acknowledged it could be contaminated with soiled laundry water that was leaking on the floor. On 6/22/20 at 3 p.m., the Administrator presented stated they had thrown away the wet boxes containing chemicals and placed the rest of the boxes on a pallet in another area of the laundry room. The Administrator stated they had identified the water leak and were in the process of repairing the washers. A review of the facility's policy and procedure titled Emerging infectious Disease Emergency & Quality Control Plan Coronavirus 2019 (COVID-2019), dated 3/20, indicated the facility would provide education and job-specific training to staff regarding COVID-19 including: correct infection control practices and personal protective equipment (PPE) use. A review of the facility's policy and procedure titled Infection Control Prevention and Control Program, revised 9/2017, indicated the goals of the infection control program were to decrease the risk of infection to residents and personnel, identify and correct problems relating to infection control practices, ensure compliance with state and federal regulation relating to infection control, and monitor employee health and safety.

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