STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. BUILDING _____ B. WING _____	07/15/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RAMONA NURSING & REHABILITATION CENTER	**11900 RAMONA BOULEVARD 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 provide a safe, sanitary environment to help prevent the spread of infection during the Coronavirus-19 (COVID-19, a respiratory illness that can spread from person to person) crisis as indicated in the facility's policy and procedure by failing to: 1. Ensure to cohort (people with the same exposure treated as a group) residents with symptoms of COVID 19 from the green zone (clean room- Negative PCR COVID-19 lab result and without known exposure within the last 14 days) to the yellow zone (QUARANTINE Unit or ROOM- Negative PCR COVID-19 lab result but exposed to lab confirmed COVID-19 (+) within 14 days). 2. Ensure to close the Residents' room doors in the yellow zone and suspected residents with symptoms. 3. Ensure to separate residents on contact isolation from residents not on any type of isolation. 4. Ensure that proper signage for the type of isolation were posted by the door to determine what kind of isolation and PPEs must be used prior to entering resident's room. 5. Ensure resident belongings were appropriately kept and not laid on the floor. 6. Ensure staff performed hand hygiene after using a touch screen clock in to work. 7. Ensure that nasal cannula- oxygen tubing (flexible plastic tubing used to deliver oxygen through nostrils and the tubing is fitted over the patient's ears) is not touching the floor. 8. Ensure to disinfect and dispose PPE according to current guidelines. 9. Ensure a single use of disposable gown for each resident care. 10. Ensure the physical plastic barrier (provide some limited protection for individuals sharing the same space, first by preventing people from getting too close and also by preventing particles or droplets exhaled by one person from entering the breathing zone of another) used for COVID-19 Infection prevention and control to separate the COVID area in the hallway from the Non-COVID area in the hallway was completely sealed and closed. These deficient practices had the potential to spread infections to other residents whose health status are already compromised, staff, and visitors. Findings: 1. During concurrent observation and interview with the Assistant Director of Nursing (ADON) on 7/15/2020 at 2:14 PM, stated room [ROOM NUMBER] was occupied with three residents and one resident with respiratory symptoms, room [ROOM NUMBER] with 1 resident with active cough, are in the green zone or clean area were isolation room and considered Yellow Zone. The ADON stated there were no appropriate poster or signage to indicate the rooms were Yellow zone. The ADON stated rooms [ROOM NUMBERS] in the green zone were isolation rooms and considered Yellow zone but no appropriate poster and signage to indicate that the rooms were Yellow zone. In addition, the ADON said that they only have the STOP sign printed in green paper to determine that the resident was for respiratory isolation (used for diseases that are spread through particles that are exhaled. Those having contact with or exposure to such a patient are required to wear a mask). The ADON stated that all isolation room door with active symptoms were open. The ADON stated the isolation room doors were open for the staff to see the residents inside the room from the hallway. During concurrent observation and interview with the ADON on 7/15/2020, at 2:18 PM, residents in rooms [ROOM NUMBER] in the Green zone, would had been moved to Yellow zone due to residents has active symptoms and has been monitored for signs and symptoms of COVID 19. The ADON stated, the residents were not moved to Yellow zone due to lack of rooms set up for Yellow zone. During concurrent observation and an interview with the ADON on 7/15/2020 at 2:35 PM, room [ROOM NUMBER] with green STOP sign by the door, ADON stated that patient was on isolation due to exposure to a roommate that came out (+) for COVID. During interview with LVN 2, he confirmed, staff assigned to Resident in room [ROOM NUMBER] was also taking care of other residents that were from green zone. 2. During observation on 07/15/2020 at 1:31 PM, yellow zone rooms [ROOM NUMBER], doors were left open. During an interview with the Director of Nursing (DON), she confirmed, it was their practice to leave the doors open for resident's room in the yellow zone. During record review of the facility's Infection Control policy COVID specific, indicated, Identified resident with suspected COVID-19 infection based on the criteria set by CDC and Public Health, will be placed in a single isolation room immediately with the door closed. 3. During concurrent observation and interview with the ADON on 7/15/2020 at 2:16 PM, room [ROOM NUMBER] have a brown STOP sign by the door indicating isolation for [MEDICAL CONDITION] (is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). The ADON stated, Resident in 57 A was on contact isolation for [MEDICAL CONDITION] infection and there was another resident in bed 57 B. ADON confirmed, resident in 57 B was not in any type of isolation. 4. During concurrent observation and interview with ADON on 7/15/2020 at 2:16 PM, room [ROOM NUMBER] have a green STOP sign poster by the door. The ADON stated, resident in 54 was on isolation for infection in the urine and not respiratory and STOP sign must by color yellow (indicating on contact isolation for urine infection). 5. During concurrent observation and an interview with the ADON on 7/15/2020 at 2:29 PM, stated that the big black plastic bag laid on the floor on room [ROOM NUMBER] contained clothes and personal belongings of the residents. The ADON stated, she did not know whose resident belongings were those and should had not laid on the floor because of the contamination. The ADON stated, she was not sure the face shield on top of the isolation cart next to Room I entrance door, belonged to and if had been used. 6. During concurrent observation and an interview with the ADON on 7/15/2020 at 2:30 PM, the staff did not perform hand hygiene before and after using the touch screen to clock in to work. During concurrent observation and an interview with the ADON on 7/15/2020 at 2:33 PM, another staff did not perform hand hygiene after using the touch screen to clock in to work. 7. During concurrent observation and an interview with the ADON on 7/15/2020 at 2:39 PM, Resident in 16 A has an oxygen tubing via nasal cannula but tubing was touching the floor, with humidifier not labeled with date and time started. The ADON stated, the oxygen tubing must not be touching the floor and the humidifier must be labeled with date and time opened. 8. During an observation on 7/15/2020 at 3:03 PM, in the Red zone PPE donning area, PPE cart was placed near the Red zone designated bathroom. During an observation, there were no visible PPE donning poster located in the donning area. A closet with multiple white jump suit and face shield hanged inside the portable closet, some labeled with the staff name and some were not. During an observation and interview with the ADON on 7/15/2020 at 3:39 PM, she stated there were no PPE doffing poster in the doffing area red zone. The ADON stated, the PPE doffing poster would need to be placed and be visible to all staff. 9. During an interview with the ADON, on 7/15/2020 at 3:05 PM, she stated that the staff used jump suit for their PPE inside the Red zone. The ADON stated, the jump suit were replaced weekly. ADON stated the staff hanged and reused the white jump suit in the closet were being reused. The ADON stated, the staff disinfect the jump suit but she was not sure how and how often the staff disinfect their PPEs including the jump suit. During an interview with CNA (certified nurse assistant) on 7/15/2020 at 3:10 PM, CNA said that on her breaktime she disinfects the jumpsuit with an alcohol spray by the doffing station and hang it there, then after her breaktime she puts it back on. During an observation and an interview with the Licensed Vocational Nurse 1 (LVN 1) on 7/15/2020 at 3:20 PM, she stated she removed her jump suit and used disposable gown in the Red zone. During an observation of the Red zone designated breakroom in the patio on 7/15/20 at 3:37 PM, multiple white jump suit and face shield hanged touching each other without any label or name to determine who it belonged to. During an interview with the ADON, on 7/15/2020 at 3:40 PM, the staff doff (remove) their PPE, jump suit and face shield outside patio where the Red zone staff designated breakroom was located. The ADON stated the staff hanged their jump suit and face shield in the patio mixed with other staff PPE to air dry. ADON stated the staff reused the jump suit, and face shield after their lunch break, and back in the red zone. 10. During an observation on 7/15/2020 at 3:03 PM, in

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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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) the red zone, plastic barrier separating Red zone from Yellow zone had a gap at the bottom allowing air to pass underneath. During an interview with the Infection Preventionist (IP) on 7/15/2020 at 5:07 PM, she stated that the residents in green zone rooms 48, 49, and room [ROOM NUMBER] had symptoms should had moved to the yellow zone since 7/11/20 or when the symptoms observed for 14 days. The IP stated, the residents with symptoms should be in the yellow zone to prevent potential cross contamination and possible exposure of residents in the green zone for COVID 19. During an interview with the Director of Nursing (DON), on 7/15/2020 at 5:42 PM, she stated that residents with symptoms would need to move to the yellow zone upon onset of the symptoms. The DON stated the facility did not had an available set up room for yellow zone and the IP was out sick during that time. The DON stated she would coordinate with the Administrator to provide an additional room for the yellow zone. During an interview with the IP, on 7/15/2020 at 6:10 PM, she stated the staff in red zone used the white jump suit all throughout their shift. The IP stated the staff in the red zone could not use a disposable gown. The IP stated the Public Health Nurse (PHN) recommended a single use of disposable gown for each residents in the red zone. The IP stated, the facility extended the use of the jump suit to mitigate PPE shortage. The IP stated the facility has enough PPE supplies. The IP stated the Administrator was aware of the PHN recommendation. During an interview with the Administrator, on 7/15/2020 at 6:13 PM, he stated that he was aware of the PHN recommendation of the single use of disposable gown for each resident in the red zone but did not implement due to concern the facility might ran out of PPE supplies. A review of the facility's undated COVID 19 Facility Mitigation Plan, Expanded Infection Control Guidance On Cohorting indicated: Place residents in three separate cohorts based on the COVID-19 PCR test results, accordingly: COVID UNIT- Positive result. Quarantine Unit or Room- Negative PCR COVID-19 lab result but exposed to lab confirmed COVID-19 (+) within 14 days. CLEAN ROOM- Negative PCR COVID-19 lab result and without known exposure within the last 14 days. Symptomatic residents with suspected COVID-19 infection may remain in their room (if multioccupancy room, with 6 feet, or as far as possible, between beds and curtains closed) while testing is pending or moved to the quarantine unit and continue. All residents who are not suspected to be infected with COVID-19 are placed in rooms or units that do not include confirmed or suspected cases, unless they are already cohorted with a symptomatic or confirmed positive roommate.