| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555742 | A. BUILDING _____ B. WING _____ | 07/21/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **INDIO NURSING AND REHABILITATION CENTER** | **47-763 MONROE AVENUE INDIO, CA 92201** |

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) |
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| F 0880<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **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 the proper infection control practices in preventing the transmission of the [MEDICAL CONDITION] infection (COVID-19 - virus causing respiratory symptoms), when: 1. The facility staff did not use the appropriate personal protective equipment (PPE - equipment worn by an individual for protection against infectious material), during provision of care requiring suctioning, for two of 35 residents (Residents A and B); and 2. A resident (Resident C) admitted with [MEDICAL CONDITION] Susceptible Staphylococcus Aureus (MSSA-infection caused by a bacteria) of the left knee, was roomed together with another resident (Resident D) under observation due to unknown COVID 19 status. These failures had the potential to result in the spread of COVID-19 infection to residents and staff. Findings: 1. On July 16, 2020, at 10:53 a.m., a concurrent interview and facility tour was conducted with the Infection Preventionist (IP). The IP stated the respiratory therapist (RT) and licensed nurses (LN) should wear face mask, gown, gloves, and face shield, when providing respiratory care such as suctioning regardless of the cohort unit (designated area for any status of infection) the residents were placed. During the facility tour, two RTs (RT 1 and RT 2) were observed inside a room in the sub-acute unit. RT 1 was observed suctioning Resident A and RT 2 was observed suctioning Resident B. The two residents (Residents A and B) have a [MEDICAL CONDITION] (a surgical incision in the neck to allow passage of air) connected to the ventilator (a machine that supplies oxygen or a mixture of oxygen and air, used in artificial respiration to control or assist breathing). RTs 1 and 2 were observed wearing gloves, and surgical mask over N95 respirator (face mask designed to prevent the entry of airborne particles). The two RTs were not wearing a face shield and a gown while providing respiratory care to Residents A and B. On July 16, 2020, at 10:56 a.m., RT 2 was interviewed, and stated that she was not wearing a gown while she was providing respiratory care to Resident B. RT 2 stated her eyeglasses was equipped with a shield at the side of it. She stated she should be wearing the appropriate PPEs (gown, gloves, face mask, and face shield) while providing respiratory care such as suctioning to the residents regardless of what cohort unit they were placed. On July 16, 2020, at 11:02 a.m., the IP was interviewed, and stated the two RTs should have worn the appropriate PPEs namely gown, gloves, face mask, and face shield, while suctioning the residents as a protection from any splashes or spray of secretions. On July 16, 2020, at 4:18 p.m., RT 1 was interviewed, and stated he was wearing gloves and face mask while providing respiratory care to Resident A. RT 1 stated he did not wear a gown and face shield. He stated he did not need to wear gown while providing respiratory care to Resident A because the resident was not on a droplet or contact precautions. RT 2 stated he would use face mask, gowns, gloves, and a face shield when conducting an open suction procedure on a resident. On July 16, 2020, at 4:35 p.m., the IP was interviewed. She stated RTs and LNs providing respiratory care such as suctioning should wear face mask, gown, gloves, and face shield regardless of whether the procedure was a close or open circuit suctioning, as there would be risk for splashes of secretions. On July 16, 2020, Residents A and B's record were reviewed. Resident A was admitted on [DATE], with [DIAGNOSES REDACTED]. Resident B was admitted on [DATE], with [DIAGNOSES REDACTED]. The facility policy and procedure titled, Standard Precautions, revised October 2018, was reviewed. The policy indicated, .Standard Precautions are used in the care of all residents regardless of their diagnoses, or suspected, or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, .may contain transmissible infectious agents .Masks and eye protection or a face shield are worn to protect mucous membranes of the eyes, nose, and mouth during procedures and resident-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions .Gowns .are worn to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, or excretions or cause soiling of clothing . A review of the web article from Centers for Disease Control and Prevention titled, Isolation Precautions, dated July 22, 2019, .During aerosol-generating procedures (procedures that stimulate coughing and promote the generation of small particles) .in patients who are not suspected of being infected with an agent for which respiratory protection is otherwise recommended .wear one of the following: a face shield that fully covers the front and sides of the face, a mask with attached shield, or a mask and goggles (in addition to gloves and gown) . 2. On July 16, 2020, at 11:25 a.m., Resident C was observed in a room with another resident (Resident D). The resident's door was observed with a signage indicating the PPE to use while providing care. In a concurrent interview with the IP, she stated Resident C [MEDICAL CONDITION] of the wound in the left knee. She stated Resident C should have been placed in a different room from Resident D. On July 16, 2020, at 1:05 p.m., the IP clarified that Resident C had MSSA infection which requires the same isolation precautions [MEDICAL CONDITION]. On July 16, 2020, Resident C's record was reviewed and indicated, Resident C was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The general acute hospital (GACH) records included a laboratory result, dated July 12, 2020, which indicated .body fluid from synovium (soft tissue in between joints) .Many Staphylococcus aureus (bacteria) . Resident C's GACH records included a physician note which indicated, .Recurrent left knee MSSA septic arthritis (infection of the joint caused by a bacteria) . Resident C's GACH records included a laboratory result, dated July 10, 2020, which [MEDICAL CONDITION] detected from the nares (nostrils). Resident D's record indicated, the resident was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. On July 16, 2020, at 2:53 p.m., the facility policy and procedure titled,[MEDICAL CONDITION] - Management of Recurrent Skin and soft Tissue Infection, revised September 2017, was reviewed with the IP. The policy indicated, .Strategies for the management of recurrent skin and soft tissue infections (SSTI) with [MEDICAL CONDITION]-resistant Staphylococcus aureus are consistent with current practice guidelines . The facility policy and procedure titled, [MEDICAL CONDITION], revised August 2019, was reviewed with the IP. The policy indicated, .Appropriate precautions are taken when caring for individuals known or suspected to have infection with a [MEDICAL CONDITION] .Room Placement .When single-resident rooms are available, assign priority for these rooms to residents with known or suspected MDRO .When single-resident rooms are not available, cohort residents with the same MDRO in the same room or resident-care area .When cohorting residents with the same MDRO is not possible, place MDRO residents in rooms with residents who are at low risk for acquisition of MDROs . A Review of the web article from Centers for Disease Control and Prevention titled, Isolation Precautions, dated July 22, 2019, .Patient placement .When single-patient rooms are in short supply .Prioritize patients with conditions that may facilitate transmission .for single-patient room placement .Place together in the same room (cohort) patients who are infected or colonized with the same pathogen (bacteria, virus, or microorganism that cause infection) . |

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