STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056487	A. BUILDING _____ B. WING _____	09/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO HONDO SUBACUTE & NURSING CENTER	273 E BEVERLY BOULEVARD MONTEBELLO, CA 90640

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies and procedures in accordance to the facility's Mitigation Plan (MP, a plan to reduce loss of life and impact of COVID-19 in the facility) for staffing strategies during an emergency, resulting in Certified Nursing Assistants (CNAs) and licensed nurses to take on higher more residents. This deficient practice resulted in Residents 1 and 2, expressing inability to be in the hallways, felt rushed when bathed, and delay in responding to call lights related to inadequate staffing. Findings: On 8/27/20 at 2:46 p.m., during interview, CNA 2 stated she was assigned to residents in the yellow (residents with unknown COVID-19 status) and the green (residents have tested negative for COVID-19) CNA 2 stated that she was usually assigned to 9-10 residents per shift prior to the start of COVID-19. CNA 2 stated she believed the facility is short on staffing because she is currently assigned 14 residents per shift, did not have sufficient time to care for 14 residents, and felt the care for the residents is compromised since. CNA 2 stated the Infection prevention nurse (IPN, a professional who make sure healthcare workers and patients are doing all the things they should to prevent infections) made projections on staffing assignments. CNA 2 stated that the Director of Staff Development (DSD) would take over staffing assignment from the IPN on 9/1/2020. 1. A review of Resident 1's admission records indicated that the facility admitted the resident on 4/22/2008 with [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS-a standardized assessment and care-screening tool), dated 2/14/2020, indicated Resident 39's has the ability to understand and make decisions. The MDS indicated the resident requires assistance for activities of daily living (ADL- transfer to or from bed, chair, wheelchair, or standing position and bed mobility, bathing, and with personal hygiene). On 8/27/2020 at 3:15 p.m., Resident 1 was observed in the hallway holding a piece of cake in her wheelchair and was not able to wheel herself back to her room. No staff observed in the hallway to assist the resident return to her room. On 8/27/2020 at 3:30 p.m., during interview Resident 1 stated the CNAs sometimes took between 20-25 minutes (mins) to answer her call light. The resident stated the staff bathed her at around 5 a.m. daily, felt as though the staff rushed through this task because they must attend to other residents. The resident stated she felt unsafe leaving her room sometimes, because other residents in the hallway have behavioral concerns, and the staff are not always nearby to monitor or redirect the residents. 2. A review of Resident 2's admission record, indicated the facility admitted the resident on 2/08/2020, with [DIAGNOSES REDACTED]. A review of Resident 2's MDS dated [DATE], indicated the resident has moderate capacity to understand and make decision, and requires assistance with ADL. On 8/27/2020 at 4:05 p.m., Resident 2 was observed in his room, on a wheelchair, and the resident's bed was not made. On 8/27/2020 at 4:15 p.m., during interview, Resident 2 stated the facility staff took around 30 mins to answer his call lights, and sometimes he wheeled himself to the nursing station to ask for help. The resident stated he is cleaned daily, however, the facility staff were pretty quick showering him. Resident 2 stated the facility staff did not always perform his oral (mouth) care in the morning. The resident stated his CNAs seemed busy sometimes or under-staffed. The resident stated he likes to be in the hallways almost every day, however, residents with behavioral and dementia residents were in the hallways sometimes, and he seldom saw the facility staff in the hallways. During record review of the facility's Staffing Assignments for the 7:00 a.m. to 3:30 p.m., shift, indicated that on: 8/2/2020, CNAs 2 and 3 assigned 14 residents each. 8/4/2020, CNA 2 assigned 15 residents, CNA 3 assigned 13 residents, and CNA 5 assigned 14 residents. 8/5/2020, CNAs 3 and 6 were assigned 14 residents each. On 9/25/2020 at 10:56 a.m., the director of staff development (DSD) stated the resident to CNA ratio, is 7-8 residents per CNA on the 7:00 a.m., to 3:00 p.m., shift. During review of the facility's Mitigation Plan under section 4.1 HCP Shortages and Crisis Contingency Strategies, it indicated the facility will ensure that there is adequate staffing during emergencies. The facility should maximize staff by utilizing registry or staff from sister companies if needed. During review of facility's Policy titled NSG112 Nursing Services it indicated the facility: 1. Will have sufficient nursing staff, including nurse aides, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient, as determined by patient assessments and individual plans of care and considering the number, acuity and [DIAGNOSES REDACTED]. 2. Will maintain an organized system for the provision of safe, effective nursing care. The system includes a staffing plan for nursing and daily care assignments and meets federal and state regulations. 3. Must ensure that licensed nurses have the specific competencies and skill sets necessary to care for patients' needs, as identified through patient assessments, and described in the plan of care. A staff's ability to use and integrate knowledge and skills must be assessed and evaluated by staff already determined to be competent in these areas. Nursing care includes, but is not limited to, assessing, evaluating, planning, and implementing patient care plans and responding to patient's needs as well as the provision of all prescribed medications and treatments, personal care, hygiene, and nursing interventions in response to physical, emotional, or behavioral needs/problems.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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 interventions to prevent and control the spread of COVID-19 (Coronavirus disease, a severe respiratory illness caused by virus and spread from person to person) in accordance to the facility's infection control policies and the Mitigation Plan (MP, a plan to reduce loss of life and impact of COVID-19 in the facility) by not: 1. Placing isolation cart (device to store personal protective equipment (PPE, gowns, gloves and masks) in resident care area) directly on the ground. 2. Providing safe storage for contaminated (soiled, infected) N95 masks (respiratory protective device) two of 20 certified nursing assistants (CNA 1 and 2). These deficient practices had the potential to result in cross contamination and the further spread of COVID-19 among the residents and staff, and the public. Findings: a. On 8/27/2020 1:39 p.m., during an observation at the yellow (residents with unknown COVID-19 status) zone, an isolation cart was observed was placed directly on the ground. Clean PPE was observed inside the isolation cart. On 8/27/2020 1:45 p.m., during an interview, the director of nursing (DON), stated he was not aware that the isolation cart to be off the ground. The DON stated he understood the potential to compromise PPE. On 8/27/2020 1:50 p.m., during an interview, the infection prevention (IP) nurse, stated the isoaltion cart was placed dircetly on the floor after one wheel broke. The IP nurse stated the practice has infection control concern because of the potential contamination of items inside the cart, and the risk of exposing residents to infectious diseases. Federal reference: According to the Centers of Disease Control and Prevention/COVID-19 updated 6/25/20 indicated that given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including [MEDICAL CONDITION]. As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is

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 -** Few	(continued... from page 1) critical to protect both residents and healthcare personnel (HCP). https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html b. On 8/27/20 at 11:36 pm., a facility visit was conducted to inspect compliance of the facility's Mitigation Plan and infection control practices. On 8/27/20 at 12:11 pm., during entrance conference, DON stated that the facility was a COVID-19 designated facility and currently had 114 residents in the green zone, 30 residents in the yellow zone, and 31 residents in the red zone. The DON stated that the facility had a two-week personal protective equipment (PPE) supply in storage and the facility was not in critical need. On 8/27/20 at 2:16 pm., during an interview, CNA 1 stated that she was working in the yellow and the green (residents have tested negative for COVID-19) zones. CNA 1 stated that the facility provided N95 mask, and did not provide surgical mask provided. CNA 1 stated that the facility instructed her to take the contaminated N95 mask home at the end of her shift. CNA 1 stated that the facility last provided her with a N95 mask was on 8/24/20 morning, and it was the fourth day wearing the same mask. On 8/27/20 at 2:45 pm., during an interview, CNA 2 stated that the facility last provided her with a N95 mask on 8/21/20, and it was the fifth day wearing the same mask. CNA 2 stated that she took the N95 mask home, and that the facility did not provide her with surgical masks. On 8/27/20 at 4:14 pm., during an interview, the IP nurse stated the N95 masks should not be worn longer for more than one shift. A review of the facility's [MEDICAL CONDITION] Disease 2019 Mitigation Plan (attachment 17) indicated that buildings where COVID-19 was confirmed, staff must wear a standard face mask at all times in all areas of the building and staff who are directly providing care to a patient who is suspected, presumed or confirmed for COVID-19 should use an N95 respirator. Reuse of N95 for at least two shifts and to follow guidance. A review of the Guidelines for Preventing and Managing COVID-19 in Skilled Nursing Facilities (page 9) revised 8/4/20 indicated that in the green, yellow, and red (COVID-19 confirmed) zones, N95 respirators may be worn for the duration of a shift or removed when contaminated.