STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056330	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REO VISTA HEALTHCARE CENTER	**6061 BANBURY ST. SAN DIEGO, CA 92139**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure transporters (individuals who pick up and drop off residents to and from the facility) were screened for covid-19 (respiratory illness caused by coronavirus) prior to entry to the facility. As a result, there was a potential for spread of infection. Findings: On 7/28/20 at 11:30 A.M., a joint interview with the Director of Nursing (DON), the administrator (ADM) and the Director of Staff Development (DSD) was conducted during a covid-19 focused survey for infection control. The DON stated there were three residents on [MEDICAL TREATMENT] in the persons under investigation (PUI) for covid-19 unit. The DON stated the transporters who pick up and drop the residents to and from the facility went through the separate entry and exit for the unit but were not screened for signs and symptoms related to covid-19 prior to entry. The DON, ADM and DSD agreed they should screen the transporters for covid-19. A record review of the Respiratory Screening Questionnaire (Covid-19) was conducted. It indicated .to protect the .patients ., are restricting all visitors and screening all visitors and employees . The facility did not provide a policy on screening of all visitors entering the facility.

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.