STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. BUILDING _____ B. WING _____	**08/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVALON HEALTH CARE - SAN ANDREAS	**900 MOUNTAIN RANCH ROAD SAN ANDREAS, CA 95249**

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.** Based on observations, interview, and record review, the facility failed to follow infection control practices for COVID-19 when: 1. Face masks were not properly worn, and 2. New admissions (Resident 2, 5, 6, 8, 9, and 11) were being cohorted with residents (Resident 1, 3, 4, 7, 10, 12 and 13) identified as COVID-19 negative and two residents (Resident 14 and Resident 16), with unknown COVID-19 status, were admitted on to a hall not designated for COVID-19 isolation and cohorted with a resident (Resident 15) identified as COVID-19 negative. These failures placed residents at risk of contracting COVID-19. Finding: 1. It was observed on 7/28/20, at 8:19 am., Housekeeper (HS) 1 was speaking to Resident 17. HS was bent down and at face level to Resident 17 who was in a wheelchair. HS1's face was approximately two feet from Resident 17's face. Both HS 1 and Resident 17 had a mask on which was placed under their chins and did not cover their mouths or noses. The conversation took place over several minutes and was elevated in volume. In an interview on 7/28/20, at 10:03 a.m. with the director of staff development (DSD) the DSD stated all staff are to wear a mask and it is to cover both the mouth and nose. In an observation on 7/28/20, at 11:20 a.m., Dietary Aide (DA) 1 was transporting rolling carts which had coffee pots and cups from the kitchen down a hallway towards the nurses stations. DA1 wore a mask which did not cover her nose. 2. During an observation in the hallway of Unit A (A wing of the facility where residents reside) on 7/28/20, at 8:37 a.m., round yellow stickers were observed next to the names of some Residents. During an interview with Certified Nurse Assistant (CNA) 1 on 7/28/20, at 8:37 a.m., CNA 1 stated the yellow stickers meant the resident was a new admission and on isolation for 14 days. Residents without a yellow sticker next to their name had passed their 14 day isolation period. When CNA 1 was asked why new admissions with yellow stickers were roomed with residents without yellow stickers, CNA 1 stated there were no available rooms to move the residents who had already passed their 14-day isolation period. During an interview with the Director of Staff Development/Infection Preventionist (DSD/IP) on 7/28/20, at 10:03 a.m., the DSD/IP confirmed the facility was taking new admissions, and Unit A is the new admission wing. The DSD/IP stated when a resident in Unit A has passed their 14-day isolation period, and have tested negative for COVID-19, the resident would be moved further up the hallway to avoid being cohorted with new admissions who were still on isolation. The DSD/IP went on to say the facility tried to cohort residents with similar admitted s. The DSD/IP stated when a new resident is admitted to a room, all residents in the room must then start their 14-day isolation period over again. During a record review of Resident 1, Resident 2, and Resident 3's ADMISSION RECORD, the records showed admitted s of 7/9/20, 7/26/20, and 7/9/20. Resident 1, Resident 2, and Resident 3 were cohorted in the same room. During a record review of Resident 4, Resident 5, and Resident 6's ADMISSION RECORD, the records showed admitted s of 6/26/20, 7/6/20, and 7/20/20. Resident 4, Resident 5, and Resident 6 were cohorted in the same room. During a record review of Resident 7, and Resident 8's ADMISSION RECORD, the records showed admitted s of 7/12/20, and 7/22/20. Resident 7 and Resident 8 were cohorted in the same room. During a record review of Resident 9 and Resident 10's ADMISSION RECORD, the records showed admitted s of 7/14/20, and 6/24/20. Resident 9 and Resident 10 were cohorted in the same room. During a record review of Resident 11, Resident 12, and Resident 13's ADMISSION RECORD, the records showed admitted s of 7/13/20, 6/8/20, and 5/28/20. Resident 11, Resident 12, and Resident 13 were cohorted in the same room. During an observation on 7/28/20 at 12:25 p.m., Resident 14 and Resident 16 had yellow dots next to their names outside the entrance to their room. Resident 14 and 16's room was located on Hall C, which was not identified as the unit to place new admissions for isolation with unknown COVID-19 status. During a record review of Resident 14, Resident 15, and Resident 16's ADMISSION RECORD, the records showed admitted s of 7/15/20, 10/13/18, and 7/16/20. Resident 14, Resident 15, and Resident 16 were cohorted in the same room with Resident 15's bed between Resident 14 and 15s beds. When the DSD was asked why new admissions on 14-day isolation were cohorted with residents who should no longer be on isolation, the DSD stated there was no available beds to move the residents to within the facility who have passed their 14-day isolation period. During an interview with the Administrator (ADM) on 7/28/20, at 11:24 a.m., the ADM stated new admissions would be considered to have COVID-19 Unknown status but there was not always available rooms in the facility to move residents to who had already completed their 14-day isolation. During a review of the facilities policy and procedure titled, Infection Prevention and Control Program (IPCP), dated 11/2017, the policy indicated, .5. A private room is desirable for a resident requiring transmission based precautions but not required. If a private room is not possible, staff will consider resident risk factors and likelihood of transmission for both residents in determining placement of resident .3. The least restrictive transmission-based precautions will be instituted for the shortest duration possible to minimize the risk of transmission and to minimize any potentially negative psychosocial effects on the resident .

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