STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055191	A. BUILDING _____ B. WING _____	**08/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVALON HEALTH CARE-MADERA	**1700 HOWARD ROAD MADERA, CA 93637**

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 observation, interview and record review the facility failed to maintain the infection prevention and control program designed to provide a safe, sanitary environment to help prevent transmission of communicable diseases and infection. Specifically, the facility failed to ensure staff donned (put on), doffed (removed), and used PPE (personal protective equipment) in accordance with accepted standards of practice to prevent potential transmission of infectious organisms from one person, object, or surface to another. Licensed Nurse (LN) 1 failed to doff a gown after exposure to bodily fluids during a finger stick blood glucose test and insulin injection, missed hand hygiene opportunities when doffing gloves, and contaminating the medication cart with the soiled gown. This failure had the potential to spread the novel [MEDICAL CONDITION] SAR-CoV-2 to other residents and staff. Findings: 1. PPE During the entrance conference on 08/06/2020 at 09:00 AM, the Director of Nursing (DON) and Administrator explained that the facility had recent outbreak of COVID-19 (the illness caused by the novel [MEDICAL CONDITION] SAR-CoV-2). As part of their public health emergency plan they had implemented facility wide precautions which directed all staff in the building to wear respirators and face shields at all times, and use transmission based precautions for COVID-19 in all rooms. A COVID-19 positive unit had been established at the north end of the building, and several rooms were designated for residents suspected of possible COVID-19 infection. During an interview with the Infection Preventionist (IP) on 08/05/2020 at 10:55 AM she described how the facility extended isolation gowns due to the limited supply. She stated, staff can use the same gown for multiple residents with the same COVID-19 status, provided they do not have any other infections, unless they come in contact with bodily fluids. During observations on 08/06/2020 at 11:45 AM of staff providing resident care, licensed nurse (LN) 1's medication cart was positioned outside of room [ROOM NUMBER]. Observed LN1 open the door from inside the room. LN1 wore an isolation gown, gloves, respirator and face shield, and held a glucometer (a device for testing blood sugar) with a used test strip in it. LN1 stated she had just completed a blood glucose test for resident 3. After disposing of test strip, disinfecting the glucometer, LN1 washed her hands at a sink inside the room. LN1 returned to the doorway, wearing the same isolation gown. LN1 stood just outside of the threshold, placed her forearms on the medication cart and typed on the computer. LN1's forearms were covered by the contaminated gown. LN1 opened the medication cart and prepared medication and an insulin device for Resident 3. During the preparation, observed LN1's isolation gown come in contact with the medication cart serval times. LN1 re-entered room [ROOM NUMBER] and closed the residents' door. She returned to the doorway a minute later and discarded used items (gloves and insulin device needle), unlocked the cart and returned the insulin device. LN1 did not perform hand hygiene after removing gloves and accessing the medication cart. LN1 walked back into room [ROOM NUMBER] for a minute, and returned to the cart, wearing same isolation gown. She stated This lady wants a pain pill referring to Resident 4 in the A bed. Observed LN1 proceeded to lean forearms covered with the contaminated isolation gown on the cart and prepare medication for Resident 4. After documenting in a log book and locking the cart, LN1 donned a pair of gloves, re-entered room [ROOM NUMBER] and administered Resident 4 the medication. A minute later, LN1 returned to the medication cart, removed and discarded the gloves then closed the door to room [ROOM NUMBER]. LN1 did not perform hand hygiene after removing the gloves, and still wore the contaminated isolation gown. LN1 then moved the medication cart positioning it outside of room [ROOM NUMBER], across the hallway. LN1 knocked on the door and reached for the door handle. Surveyor stopped LN1 prior to entering the room. Immediately interviewed LN1 about wearing the contaminated gown into the hallway, between residents, and touching the cart with the contaminated gown at 11:55 AM. LN1 confirmed the gown was contaminated after completing the blood glucose testing, calling it dirty and stated I've contaminated the cart. When asked what could happen if she wore a contaminated isolation gown with other residents, she stated it could spread COVID. She further stated she did not know why she had continued to wear the gown, I would typically discard the gown. Interviewed the DON on 08/06/2020 at 12:00 PM, the Infection Preventionist (IP) was also present. When they were made aware of the observation of LN1 failing to doff the contaminated gown, contaminating the cart, and preparing to enter another resident room, the IP stated I'll go and in-service her right now. The DON described the outside of the cart as dirty and that nurses have to disinfect it. When asked about the medication cart being contaminated, she stated That would be a concern. When asked about their transmission based precautions, the DON stated, she can't wear a gown into another room if she did a glucose check, we know she touched the resident. Resident 3's electronic health records (E HR) were reviewed on 0806/2020. The Admission Record read Resident 3 was admitted to the facility on [DATE] for care following surgery on the digestive system. Resident 3's [DIAGNOSES REDACTED]. Resident 3's Medication Administration Record [REDACTED]. Facility policy titled COVID-19 dated 05/01/2020 read under Key Concepts The facility will implement measures to protect healthcare personnel such as . Following CDC Guidelines for use of Personal Protective Equipment. CDC Guidance titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated 07/15/2020 read, Gowns - Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area

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