STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055310	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARIN POST ACUTE	234 N. SAN PEDRO RD SAN RAFAEL, CA 94903

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 observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to prevent the transmission of COVID-19 when: - Hand sanitizer dispensers were not readily available for staff and visitors to perform hand hygiene prior to resident care; - Staff and visitors did not perform hand hygiene prior to and after resident care; - Staff did not use Personal Protective Equipment (PPE) according to CDC guidelines during resident care; and, - The facility failed to ensure PPE carts, located outside resident rooms for staff don (put on) prior to entering resident rooms, were adequately stocked with the necessary supplies (masks, gowns, gloves and facial shields). These failures created the potential for the spread of COVID-19. Findings: During an interview on 7/16/20, at 10:15 a.m., the Administrator stated the facility had 86 residents and 46 of those had tested positive for COVID-19. The COVID-19 positive residents were placed in a separate section of the facility called the COVID-19 unit, on the second floor. The Administrator stated he had implemented Droplet Precautions throughout all the facility, for all residents, to prevent the spread of COVID-19 in the facility. According to the Centers for Disease Control and Prevention, Droplet Precautions required staff to use the following Personal Protective Equipment (PPE) when providing care to residents: Gloves, facemask (N 95 respirator preferred), gown and face shield (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html). The CDC guidance for the sequence of donning PPE, copies of which were located outside resident rooms in the facility, indicated the PPE should be donned outside the resident's room and staff should, perform hand hygiene using hand sanitizer, prior to donning PPE and entering the room and after removing the PPE (www.cdc.gov/coronavirus). The CDC recommended hand sanitizer dispensers be readily available for staff: Healthcare facilities should . Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered. (https://www.cdc.gov/handhygiene/providers/guideline.html) A review of the facility's floor plan, provided by the Administrator on 7/16/20, at 10:15 a.m., revealed 39 resident rooms on the first floor and 34 on the second floor. During observations of the facility on 7/16/20, starting at 10:55 a.m., there were 11 wall-mounted hand sanitizer dispensers on hallways and public areas on the first floor and eight on the second floor, with a combined average of one hand sanitizer dispenser for every four resident rooms. A cross-reference of resident room and wall-mounted hand sanitizer dispenser locations, revealed hand sanitizer dispensers were not readily available for staff and visitors to use prior to entering resident rooms. For instance, a staff or visitor wishing to enter a room on the first floor, would have to walk past three resident rooms to reach the hand sanitizer dispensers. Similarly, on the second floor, to enter a resident room, staff or visitors would also have to walk past three resident rooms to reach the hand sanitizer dispenser. During an observation on 7/16/20, at 10:55 a.m., Licensed Nurse A was providing care to residents on the second floor of the facility in the hallway comprising 11 resident rooms. A total of two hand sanitizer dispensers were in this hallway. An inspection of the PPE carts in front of the rooms did not reveal hand sanitizer bottles. Licensed Nurse A was asked where she performed hand hygiene prior to entering resident rooms. Licensed Nurse A stated she either used the two wall-mounted dispensers or the hand sanitizer bottle located on the medication cart. Licensed Nurse A stated staff were not provided with individual hand sanitizer bottles but one was available in the medication cart. During an observation on 7/16/20, at 11:25 a.m., Licensed Nurse B was working on the second floor in the facility's COVID-19 unit (where residents who tested positive for COVID-19 stayed). Licensed Nurse B went into a resident room to provide care to three residents and did not perform hand hygiene before donning PPE and entering the room or after removing the PPE and leaving the room. There was no hand sanitizer dispenser outside this room. The closest hand sanitizer dispenser was located three resident rooms away. During an observation on 7/16/20, at 11:30 a.m., Certified Nursing Assistant (CNA) C was working on the second floor in the facility's COVID-19 unit. CNA C went into a resident room to provide care for three residents and did not perform hand hygiene prior to entering and before leaving the room. There was no hand sanitizer dispenser readily accessible outside this room. During an observation and interview on 7/16/20, at 11:40 a.m., a visitor was on the second floor in the facility's COVID-19 unit. The visitor donned PPE went into a resident room, which had three residents. The visitor did not perform hand hygiene prior to donning PPE and entering the room. Prior to leaving the room, the visitor removed all PPE but did not perform hand hygiene. The visitor stated she did not perform hand hygiene before entering and after leaving the room because there was no hand sanitizer dispenser outside the room. The hallway where this room was located showed there were nine rooms and two hand sanitizer dispensers, one two rooms away and one in front of the beauty shop. During an observation on 7/16/20, at 1:25 p.m., Licensed Nurse E was providing resident care in a resident room on the first floor of the facility. Two hand sanitizer dispensers were in this hallway, one at the beginning of the hallway in front of the Director of Nursing's (DON) office and one at the other end in front of the oxygen storage room. A review of the PPE carts in front of the rooms did not reveal hand sanitizer bottles. Licensed Nurse E was asked where she performed hand hygiene prior to entering resident rooms, and stated she either used the two wall-mounted dispensers or the hand sanitizer bottle located on the medication cart. Licensed Nurse E stated staff were not provided with individual hand sanitizer bottles but one was always available in the medication cart. During an observation on 7/16/20, at 1:30 p.m., CNA F went into a resident room to provide care to one resident. CNA F did not don any PPE and did not perform hand hygiene prior to going in the room. Inside the room, CNA F washed his hands in the room's sink, put on gloves and removed dirty linen. CNA F then left the room, still gloved, holding the dirty linen and placed it in a container on the hallway. CNA F then returned to the room, removed his gloves, washed his hands in the room's sink and left the room. Outside the room, there were CDC signs posted indicating the need to don PPE and perform hand hygiene using hand sanitizer before going into the room and prior to leaving the room. During a concurrent interview, CNA F was asked why he washed his hands and put on gloves inside the room instead of using hand sanitizer and donning PPE outside the room, as recommended by the CDC signs posted outside the room. CNA F stated he did not know. The PPE cart outside this room indicated no gloves and no hand sanitizer. A box of gloves was located inside the room near the sink. The CDC recommended alcohol-based hand sanitizer over the use of soap and water in clinical settings: Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/hand-hygiene.html) During interviews on 7/16/20, at 1:15 p.m., Licensed Nurses A and B, who were working in the facility's COVID-19 unit on the second floor of the facility, stated PPE carts were placed right outside resident room doors and should contain gowns, gloves, N 95 respirators (a type of facemask that filters 95% of air particles), face shields and hand sanitizers for them to use. Licensed Nurses A and B stated maintenance was responsible for stocking the PPE carts. During observations on 7/16/20, starting at 1:15 p.m., multiple PPE carts located throughout the facility in front of resident rooms did not contain a complete supply of PPE, as follows: 13 PPE carts missing N 95 respirators and face shields; Six PPE carts missing gloves; two PPE carts missing N 95 respirators; two PPE carts missing gowns; and two PPE carts missing face shields. During an interview on 7/16/20, at 1:30 p.m., Certified

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 -** Some	(continued... from page 1) Nursing Assistant (CNA) G was asked where the facility kept a supply of N 95 respirators and stated, There's a box of N 95s inside the Utility Room. CNA G searched the Utility Room but found no N 95 respirators. During a concurrent interview, Licensed Nurse B stated: We keep it in the room behind the nurses station, but no supply of N 95 masks was found in the room. During an interview on 7/16/20 at 2:30 p.m., the Director of Staff Development (DSD) and the Director of Nursing (DON) stated the Personal Protective Equipment (PPE) carts outside of resident rooms should have facemask's (N 95 respirators), gloves, gowns, face shields and hand sanitizer. They stated staff should put on PPE before entering the residents' rooms. The DON and DSD also stated staff were expected to perform hand hygiene and don PPE outside, prior to entering resident rooms and should doff PPE and perform hand hygiene prior to leaving resident rooms. A review of the facility Policy & Procedure titled, Personal Protective Equipment, Revised October 2018, indicated 2) Personal protective equipment provided to our personnel includes gowns/aprons/lab coats (disposable, clothes, and or plastic), gloves, mask and eyewear (goggles and or face shields) . 4) A supply of protective clothing and equipment is maintained at each nurses' station. PPE required for transmission-based precautions is maintained outside and inside the resident's room as needed .7) Visitors and residents are ask to comply with transmission-based precautions are educated on the proper use of PPE and provided with equipment at no charge. A review of the facility Policies & Procedures titled, Personal Protective Equipment - Contingency and Crisis Use of N-95 Respirators, Isolation Gowns and Eye Protection (Covid-19 Outbreak), dated April 2020, indicated the objective for N 95 masks, eye protectors and gowns was, to prevent transmission of infectious agents through the inhalation of airborne particles or droplet nuclei.