STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555353	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA HEALTH CARE CENTER	8965 MAGNOLIA AVENUE RIVERSIDE, CA 92503

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection prevention and control practices to prevent the transmission of the [MEDICAL CONDITION] infection (COVID-19 - virus causing respiratory symptoms), when: 1. The facility staff did not use the appropriate personal protective equipment (PPE - equipment worn by an individual for protection against infectious material), during provision of care for two of 12 new admit residents with unknown COVID 19 status (Residents 1 and 2); and 2. There was no sign posted outside the resident's room to indicate the appropriate infection control and prevention precautions and required PPE needed in providing care for residents with unknown COVID 19 status. These failures had the potential to result in the spread of COVID-19 infection to residents and staff. Findings: On June 16, 2020, at 9:28 a.m., a focused survey was conducted to investigate facility compliance on appropriate infection control and prevention practice. On June 16, 2020, at 9:32 a.m., an entrance conference was conducted with the Administrator, the Infection Preventionist (IP), and the Director of Nursing (DON). During the entrance conference, the IP stated the rooms designated for new admits were Rooms 9,10, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, and 25 (total of 36 beds). She stated the staff should have N95 respirator (face mask designed to prevent the entry of airborne particles), gown, and gloves, when entering the designated room for the new admits. On June 16, 2020, a facility tour was conducted and the following were observed: a. At 11:18 a.m., Resident 1 was exercising inside the resident's room (room [ROOM NUMBER]). Resident 1 was being assisted by a staff member (Occupational Therapy Assistant-OTA). A Physical Therapy Assistant (PTA) was at the resident's bedside observing. The two staff (PTA and OTA) were wearing gloves, surgical mask over an N95, and a face shield; There was no sign posted by the door indicating the type of precautions needed for Resident 1. b. At 11:22 a.m., a concurrent observation and interview was conducted with the IP on the infection control practice of the two staff members (PTA and OTA) while providing care to Resident 1. She stated Resident 1 was a new admit. The IP stated the two staff should be wearing a surgical mask over the N95, gown, and gloves while providing care to Resident 1. She stated the use of a face shield is optional. The IP stated there was no sign posted by the resident's room on what precaution should the staff observe prior to entering the resident's room; c. At 11:31 a.m., at room [ROOM NUMBER] (a designated room for new admit) a blue gown was hanging by the door. There was no sign posted to indicate what type of precautions the staff should observe prior to entering the room. At room [ROOM NUMBER] (not designated for new admits) there were two residents inside the room; and d. At 11:35 a.m., at rooms [ROOM NUMBER], blue gowns were hanging by the door; There was no sign posted on the resident's door to indicate the type of precautions the staff should observe prior to entering the room. In a concurrent review of records, the residents residing inside Rooms 12, 23, 24, and 25, were new admits. On June 16, 2020, at 11:42 a.m., Licensed Vocational Nurse (LVN) 1 was interviewed. She stated new admit residents were placed in Rooms 22, 23, 24, and 25. She stated the staff should be wearing gown, gloves, surgical mask over N95 respirator and a face shield prior to entering the rooms of the new admit resident. On June 16, 2020, at 12:10 p.m., the ADM was interviewed. He stated the rehab staff should be wearing the blue gown while conducting treatment to Resident 1. On June 16, 2020, at 12:51 p.m., the OTA was interviewed. She stated she was wearing face shield, gloves, and surgical mask over N95 respirator, when she provided treatment to Resident 1 earlier that morning. The OTA stated she did not wear a gown. She stated she was not aware whether Resident 1 was a new admit resident or not. She further stated the Rehabilitation Director had instructed her of infection control protocols for symptomatic residents, but not for new admit residents. On June 16, 2020, at 1:49 p.m., a housekeeping cart was observed outside room [ROOM NUMBER] (a designated room for new admit). Two blue gowns were observed hanging by the door of room [ROOM NUMBER]. The housekeeper (HSKP) was observed mopping the floor of room [ROOM NUMBER], wearing gloves, and surgical mask over N95 respirator. There was no sign posted by room [ROOM NUMBER]'s door to indicate what kind of precaution should the staff observe prior to entering the room. In a concurrent interview with the HSKP, she stated the new admit resident is placed on isolation. The HSKP stated a sign would be posted by the resident's room indicating what isolation precautions and PPE to use. She stated she would use gown, gloves, and surgical mask over N95 respirator when she enters the room designated for new admit. The HSKP stated she was not aware the residents inside room [ROOM NUMBER] were new admits, and she entered the room to clean without wearing a gown. On June 16, 2020, at 2:02 p.m., the PTA was interviewed. She stated she was at room [ROOM NUMBER] this morning while the OTA was conducting treatment on Resident 1. She stated she was aware Resident 1 was a new admit resident. She stated she wears N95 respirator and face shield when she enters the room for new admit resident. The PTA stated it was optional to wear the blue gown while doing treatment with new admit residents. The PTA stated she had not been wearing the blue gown while she provide treatment to new admit residents. On June 16, 2020, at 2:38 p.m., Certified Nurse Assistant (CNA) 1 was interviewed. CNA 1 stated she was assigned to take care of residents in Rooms 14, 15, 16, 17, 18, and 19 (designated for new admits). She stated she would wear gown, gloves, and N95 respirator when entering the resident's room for new admit. CNA 1 stated the resident in room [ROOM NUMBER] was a new admit. She stated she was not aware the two residents in room [ROOM NUMBER] were new admit, so she did not wear the blue gown when she provided care for these two residents (Residents 1 and 2). She stated she should have worn a blue gown together with N95 and gloves when she provided care to Residents 1 and 2. On June 16, 2020, Residents 1 and 2's records were reviewed. Resident 1 was admitted to the facility on [DATE] (eight days prior to date of survey). Resident 2 was admitted to the facility on [DATE] (six days prior to date of survey). In addition, the resident at room [ROOM NUMBER] was admitted to the facility on [DATE] (four days prior to date of survey). On June 16, 2020, at 3:10 p.m., the ADM, IP, DON, and Quality Consultant (QC) were interviewed. The QC stated facility staff should use N95 respirator, gloves, gown and face shield when providing care to residents with suspected or unknown status of COVID-19. The ADM and QC stated the gown was optional for the staff to use when providing care to new admit residents as they are not considered suspected COVID-19 residents. On June 18, 2020, at 2:57 p.m., the IP was interviewed. The IP stated the staff should wear a gown when providing care for new admit residents and the use of the gown was not optional. The IP stated there should be designated staff to take care of the residents suspected of COVID 19. She stated there should be signage outside the door to indicate the appropriate PPEs to use during provision of care for residents under monitoring. According to the web article from the Centers for Disease Control and Prevention (CDC) titled, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, updated May 18, 2020, .Mode of Transmission .Current data suggest person-to-person transmission most commonly happens during close exposure to a person infected with [MEDICAL CONDITION] that causes COVID-19, primarily via (through) respiratory droplets produced when the infected person speaks, coughs, or sneezes .Transmission also might occur through contact with contaminated surfaces followed by self-delivery to the eyes, nose, or mouth .Ensure facility policies and practices are in place to minimize exposures to respiratory pathogens including [DIAGNOSES REDACTED]-Cov-2 (COVID-19) .Measures should be implemented before patient arrival, upon arrival, throughout the duration of the patient's visit, and until the patient's room is cleaned and disinfected .HCP (Health Care Personnel) . who enter the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions (minimum infection

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) prevention practices that apply to all patient care, regardless of suspected or confirmed infection status) and use a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection .Patient Placement .As a measure to limit HCP exposure and conserve PPE, facilities should consider designating entire units within the facility, with dedicated HCP, to care for patients with known or suspected COVID-19. Dedicated means that HCP are assigned to care only for these patients during their shift . According to the web article from CDC titled, Preparing for COVID-19 in Nursing Homes, updated May 19, 2020, .Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown .include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents . The undated facility policy and procedure titled, COVID-19 FACILITY GUIDANCE PROTOCOL, was reviewed. The policy indicated, .This protocol is to provide guidance to facility staff in admitting or receiving residents with suspected or positive COVID-19 infections, how to mitigate, manage and prevent the spread of COVID-19 within the facility .As a measure to limit Healthcare Staff exposure and conserve PPE .a unit within the facility will be designated for the purpose of admitting known or suspected COVID-19 patients .Dedicated healthcare staff will be assigned to care for suspected or confirmed COVID-19 residents during their shift .Place residents in three separate cohorts based on the test results .Positive result .Negative result but exposed within 14 days .Negative result without known exposure within the last 14 days . The facility policy and procedure titled, Isolation - Categories of Transmission-Based Precautions (infection-control precautions in addition to standard precautions), revised January 2012, was reviewed. The policy indicated, .Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others .implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment .Wear a disposable gown upon entering the Contact Precautions room .Signs - The facility will implement a system to alert staff to the type of precaution resident requires .