STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055474	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA REHABILITATION & NURSING CENTER	**8133 MAGNOLIA AVENUE RIVERSIDE, CA 92504**

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on interview and record review, the facility failed to ensure sufficient nursing staff was provided, when: 1. Multiple facility staff stated there was insufficient nursing staffing on multiple days, 2. Residents 1, 2, and 3's responsible parties stated there were delays with the staff's response to call lights and shortage of Certified Nursing Assistants (CNAs) on various shifts, and 3. The facility was staffed below the state-mandated minimum nursing staffing requirements on multiple dates. These failures had the potential for the residents in the facility to not receive timely and necessary nursing care and related services to assure the residents' safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings: On June 15, 2020, at 1:01 p.m., an unannounced visit to the facility was conducted to investigate a complaint related to insufficient staffing. 1. On June 17, 2020, at 10:28 a.m., the Assistant Director of Nursing (ADON) was interviewed. The ADON stated the facility was short of staff on multiple days when the facility had an outbreak of COVID-19. On June 17, 2020, at 1:20 p.m., the Director of Staff Development (DSD) was interviewed. The DSD stated there was a staffing shortage when the facility had a outbreak of COVID-19, and there were multiple call-offs from staff on various shifts. 2. On June 23, 2020, at 4:40 p.m., Resident 2's Responsible Party (RP) was interviewed. Resident 2's RP stated the facility management did not provide appropriate staffing to take care of the residents. Resident 2's RP further stated because of the lack of staffing his family member did not receive the proper level of care in the facility. On June 23, 2020, at 4:50 p.m., Resident 3's RP was interviewed. Resident 3's RP stated, The facility needs more staffing. Resident 3's RP further stated there were days his wife had to wait for hours to receive care. On June 25, 2020, at 1:30 p.m., Resident 1 was interviewed. Resident 1 stated the staffs' response to call lights were slow during the PM shift (3 p.m. to 11 p.m.) and NOC shift (11 p.m. to 7 a.m.), and sometimes took up to one to two hours to receive assistance from staff. Resident 1 further stated the facility had a staffing shortage especially during the weekends. 3. According to Title 22 California Code of Regulations .2(a) Each facility, except those skilled nursing facilities that are a distinct part of a general acute care facility or a state-owned hospital or developmental center, shall employ sufficient nursing staff to provide a minimum of 3.5 direct care service hours per patient day, except as set forth in Health and Safety Code section 1276.9. Skilled nursing facilities shall have a minimum of 2.4 hours per patient day for certified nurse assistants to meet the requirements of this subdivision. On June 17, 2020, at 2:30 p.m., an interview and concurrent record review was conducted with the Director of Staff Development (DSD) and the Human Resources Director (HRD). The form titled, Census and Direct Care Service Hours Per Patient Day (DHPPD, a state required form which reflects the facility's total number of nursing hours and nursing hours performed by direct caregivers per patient per day), for the months of February thorugh April 2020, were reviewed. The DHPPD for February 2020, indicated the facility was below the minimum requirement of 2.4 hours per patient per day for direct care service hours performed by CNAs for six of 28 days of the month (February 14, 15, 16, 20, 22, and 23). The DHPPD for March 2020, indicated the facility was below the minimum requirement of 3.5 direct care service hours for two of 31 days of the month (March 8 and 14), and below the minimum requirement of 2.4 hours per patient per day for direct care service hours performed by CNAs for 13 of 31 days of the month (March 1, 5, 6, 7, 8, 9, 10, 12, 14, 16, 22, 28, and 29). The DHPPD for April 2020, indicated the facility was below the minimum requirement of 3.5 direct care service hours for four of 30 days of the month (April 5, 6, 7, and 8), and below the minimum requirement of 2.4 hours per patient per day for direct care service hours performed by CNAs for seven of eight days in April prior to the evacuation of the facility's residents on April 8, 2020 (April 2, 3, 4, 5, 6, 7, and 8). On June 18, 2020, at 9:40 a.m., the HRD was interviewed. The HRD stated the facility did not meet the minimum staffing requirements on February 14, 15, 16, 20, 22, 23, March 1, 5, 6, 7, 8, 9, 10, 12, 14, 16, 22, 28, 29, and April 2, 3, 4, 5, 6, 7, 8, for total of 26 days. On June 18, 2020, at 10:15 a.m., the DSD was interviewed. The DSD stated the facility had a nurse staffing shortage especially during the outbreak of COVID 19. The DSD stated the facility had been using registry (temporary staff) nursing staff because they did not have enough staff. On June 18, 2020, at 10:30 a.m., the Director of Nursing (DON) was interviewed. The DON stated the facility had a nurse staffing issue. The DON stated the facility had a shortage of CNAs. The DON stated there was an increase in call offs and the staff were given instructions not to come to work after the staff were tested for COVID-19. On June 18, 2020, at 10:40 a.m., the Administrator was interviewed. The Administrator confirmed the facility did not meet the minimum requirement of 3.5 direct care service hours for the month (March 8, 14, April 5, 6, 7, and 8, 2020), and below the minimum requirement of 2.4 hours per patient per day for direct care service hours performed by CNAs for the month (February 14, 15, 16, 20, 22, 23, March 1, 5, 6, 7, 8, 9, 10, 12, 14, 16, 22, 28, 29, and April 2, 3, 4, 5, 6, 7, 8) total of 26 days. The facility's policy and procedure titled, Staffing, dated April 2007, was reviewed. The policy indicated, .Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care and services. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan .
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 interview and record review, the facility failed to ensure proper infection control preventive measures were implemented when multiple staff reported the lack of adequate and appropriate personal protective equipment (PPE- specialized clothing or equipment worn by health care workers for their protection and to help prevent the spread of infection between patients; PPE includes but is not limited to gloves, gowns/aprons, goggles or face shields, facemasks and respirators) was provided during care of residents with identified or potential Coronavirus disease (Covid19- an illness caused by [MEDICAL CONDITION] that can spread from person to person, causing wide range of symptoms- from mild to severe illness). This failure increased the potential for the transmission of infectious disease between staff and residents. Findings: On May 4, 2020, an investigation was initiated related to infection control practices in the facility. On May 4, 2020, at 2:15 p.m., Certified Nursing Assistant (CNA) 1 was interviewed and stated when she came in to work on April 2, 2020, she was told there were no isolation gowns available and had to hunt down for surgical masks to use that day. She stated a lady from the office told her to wear hospital gowns with trash bags. On May 4, 2020, at 2:48 p.m., CNA 2 was interviewed and stated she heard from other CNA staff that they had to wear hospital gowns and trash bags due to gowns being used very fast in April 2020. On May 5, 2020, at 10:36 a.m., CNA 8 was interviewed and stated there were very limited PPE during the time she worked in the facility in March and April 2020. On May 5, 2020, at 12:42 p.m., CNA 11 was interviewed and stated on April 5, 2020, one of the staff told her there were no face masks or isolation gowns available, and they had to wear patient gowns. She stated some CNAs did not want to work because there were not enough PPE. She stated

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) staff were not comfortable wearing and sharing the same PPE. On May 5, 2020, at 4:20 p.m., CNA 13 was interviewed and stated the facility did not have enough isolation gowns when she worked on April 5, 2020. She stated Station 2 had one potential Covid resident and there were no yellow gowns, referring to the isolation gowns. She further stated, They wanted us to use hospital gowns .one of the staff had to wear trash bags over hospital gowns . On May 6, 2020, at 8:53 a.m., CNA 14 was interviewed and stated she worked in the facility on April 3, 4, and 5, 2020. She stated a lot of the facility staff were having (Covid) symptoms. She stated the head/shower caps (PPE) were being shared by staff per room for the whole shift during one of the days she worked in the facility. On May 6, 2020, at 2:13 p.m., CNA 18 was interviewed and stated she worked in the facility on April 3, 4, and 5, 2020, and called off on April 7, 2020. She stated when she worked on April 4 and 5, 2020, she had to go around to different stations to look for masks. On May 6, 2020, at 3:21 p.m., CNA 19 was interviewed and stated she worked from April 1 to 5, 2020. She stated there were days when there was no proper PPE and had to wear patient gowns with nothing to cover her arms. On May 6, 2020, at 4:36 p.m., CNA 20 was interviewed and stated PPEs were okay during the first day but had shortage of gowns and masks later on. On May 7, 2020, at 1:32 p.m., LVN 6 was interviewed and stated a lot of residents tested positive for COVID in April 2020. She stated there was a time she only wore a surgical mask since there was no N95 mask (a type of respirator which removes particles from the air that are breathed through it. These respirators filter out at least 95% of very small particles, including bacteria [MEDICAL CONDITION]) available. She stated some of the staff were using patient gowns, plastic bags and trash bags onto their heads. She stated there were no goggles or face shields available at that time. On May 7, 2020, at 3:30 p.m., CNA 22 was interviewed and stated she worked in the facility on April 5, 6, 7, and 8, 2020. She stated on April 5, 2020, she worked in a unit with approximately six to seven rooms on Covid isolation precautions. She stated she wore patient gowns over isolation gowns so she could reuse the gowns as there were not enough PPE gowns available. On May 8, 2020, at 4:08 p.m., CNA 27 was interviewed and stated the PPEs were not very good-not enough during the time she worked in the facility in April 2020. She stated she had to wear the same isolation gown for the whole day. On May 12, 2020, at 11:58 a.m., LVN 8 was interviewed and stated there were no N95 masks available on April 6, 2020, until the county public health staff came in and provided PPE supplies. From the online publication Science Daily, in its article titled, PPE, plus training, lowers risk of COVID-19 for health care workers, dated May 5, 2020, indicated: Health care workers carry a significant burden of coronavirus infections worldwide, but a new evidence review by researchers at Oregon Health & Science University shows the rate can be lowered with the use of personal protective equipment combined with proper training in infection control. The review, funded by the World Health Organization, published today in the Annals of Internal Medicine. Most people understand it's a high priority to protect our nurses and doctors . In addition to the impact that COVID-19 would have on infected health care workers, they can pose a transmission risk. Plus, they can't work if they become infected, and maintaining health care capacity throughout the pandemic is important. Adequate supplies of personal protective equipment such as masks, gowns and eye protection have been the subject of heightened attention throughout the pandemic . The evidence suggests that lowering the rate of infection among health care workers must also include adequate training and education to ensure workers use the equipment properly. Infection control training is important . It's not just about providing the equipment, but helping health care workers understand how they need to use it. Training and education were consistently associated with decreased risk of infection .