STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555844	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NOVATO HEALTHCARE CENTER	**1565 HILL ROAD NOVATO, CA 94947**

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.** Based on observation, interview and record review the facility failed to: 1. Provide Personal Protective Equipment (PPE) coaches, responsible for providing just-in-time education on donning (putting on) and doffing (removing) PPE; 2. Develop a policy for donning/doffing PPE appropriately and ensure Centers of Control Disease (CDC) guidelines were followed, when a staff member (Staff member A) was observed doffing PPE incorrectly after being in contact with COVID-19 positive residents; and, 3. Ensure adequate PPE was used prior to entering a potentially COVID-19 infected area, when a staff member (Housekeeper B) was observed entering a designated yellow room without the required PPE. These findings had the potential to result in breaks in infection control, leading to exposure to the COVID-19 virus, which can lead to death in vulnerable individuals. Findings: 1. During an interview on 8/31/20 at 1:30 p.m., the facility's Infection Preventionist (IP) stated the facility had not designated PPE coaches, every shift, responsible for just-in-time education on donning and doffing PPE, other than herself. The IP worked full-time at the facility, but there were shifts and days when she did not work. The IP stated the most recent training on PPE donning and doffing was provided on 8/5/20. 2. During an observation and concurrent interview with the IP on 8/31/20 at 2:08 p.m., outside the unit housing COVID-19-positive residents, Staff A exited the COVID-19-positive unit in full PPE (Gown, mask, face shield and gloves) and doffed the gown and gloves outside the unit, in the hallway of the facility. The IP confirmed the observation, and stated, I saw that too, the doffing should be done inside. During an interview on 9/1/20 at 10:46 a.m., Staff A stated she was in the COVID-19-positive unit all day on 8/31/20, and she was going out for her lunch when she exited the unit. Staff A stated she was trained to doff her PPE, including gloves and gown, outside the COVID-19-positive unit, in the hallway, as observed. During an interview on 9/1/20 at 1:46 p.m., the IP was asked for the policy or procedure on correctly donning and doffing PPE. The IP stated the facility did not have a policy on donning and doffing PPE, and instead, used CDC guidelines. 3. During an observation in station four of the facility, on 9/1/20 at 10:08 a.m., a housekeeper (Housekeeper B) entered a room designated as a yellow room (Room housing a resident under investigation for COVID-19) to perform her duties. Housekeeper B was wearing a facemask and a face shield. Housekeeper B left her cart in the hallway right by the entrance of the room. The room had two beds, but only one bed was occupied. A resident was inside the room in a bed. Housekeeper B proceeded to don gloves. Housekeeper B did not put on a gown before entering the room. Housekeeper B cleaned around the bed where the resident was laying, less than six feet away from the resident and not wearing a gown. During an interview on 9/1/20 at 10:15 a.m., in the hallway of the facility, Housekeeper B was asked what type of PPE was required to be worn when entering yellow rooms. Housekeeper B stated staff were required to wear a gown, face shield, mask and gloves. Housekeeper B was notified about the earlier observation, where she entered a yellow room without the gown. Housekeeper B confirmed the observation, and stated, Sorry. When asked what happened, Housekeeper B stated she had forgotten to put on the gown prior to entering the yellow room. During an interview with the IP on 9/1/20 at 1:30 p.m., the IP stated all staff entering the yellow rooms were required to wear gowns, regardless of whether they provided direct patient care or not. The facility's approved Mitigation Plan, last revised 5/29/20, indicated, Individuals serving as PPE coaches, who are responsible for providing just-in-time education to direct care staff, have been designated for each shift to identify and support adherence with PPE policies. An article by CDC titled, Using Personal Protective Equipment (PPE), last updated on 8/19/20, indicated, How to Take Off (Doff) PPE Gear .1. Remove gloves. Ensure glove removal does not cause additional contamination of hands . 2. Remove gown .3. Healthcare personnel may now exit patient room. This article indicated gloves and gowns were to be removed prior to exiting the infected area.

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