STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055708	A. BUILDING _____ B. WING _____	09/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LEGACY POST-ACUTE REHABILITATION	**1335 N. WATERMAN AVENUE SAN BERNARDINO, CA 92404**

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** - Many	**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 development and transmission of COVID-19 in a universe of 88 residents when: 1. Facility Staff did not follow transmission based precautions (precautions used to help stop the spread of germs from one person to another) to prevent the spread of infection for Residents 1, 2, 3, 4, and 5 when a Licensed Vocational Nurse (LVN 1) failed to wear a gown or face shield/goggles and Licensed Vocational Nurse (LVN 2) failed to wear a gown or face shield/goggles when entering a droplet precaution isolation room (droplet isolation precautions are used for infections, diseases, or germs that are spread to others by speaking, sneezing, or coughing. Healthcare workers should wear a gown, mask, and goggles or face shield while in the patient's room). 2. The facility did not provide a private room, cohort (placing residents with the same infection or potential infection in the same room) or apply mitigation strategies (beds six feet apart, privacy curtains drawn and room door closed) to reduce infection transmission for Residents 1, 2, 3, 4, and 5. This failure had the potential to cause an infection to spread to other residents of the facility. During an interview with the Infection Preventionist (IP) on August 26, 2020 at 9:17 AM, the IP stated the facility had been broken up into two units: the yellow zone unit and the COVID unit. The COVID unit was for residents confirmed to be infected with COVID 19. The yellow zone unit was for residents who were new admissions and considered Persons Under Investigation (PUI) for possible COVID 19 infection. The residents in the yellow zone unit had been placed on droplet precaution isolation for 14 days. The IP confirmed that Resident 1 and 5 were new admissions to the facility and had been placed on droplet precaution isolation for 14 days. 1a. A review of Resident 1's face sheet (a document that gives a summary of resident's information), undated, indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 occupied a room on the Yellow Zone Unit (designated to be used and occupied by those residents whose COVID 19 infection status was unknown) of the facility. During an observation of a room on the yellow zone unit on August 26, 2020 at 10 AM, a name plate mounted on the wall, next to the room's door, indicated the name of Resident 1. There was no signage outside of the room to indicate droplet precaution isolation. No isolation cart (a cart containing personal protective equipment-PPE-required for entrance into an isolation room) was positioned outside of the room. The door of the room was open and two residents were visualized in side by side hospital beds. The privacy curtain was not drawn between the residents' beds. A Licensed Vocational Nurse (LVN 1) entered the room and checked Resident 1's feeding pump. LVN 1 wore a cloth face covering. LVN 1 did not don (to put on) a gown, gloves, goggles or face shield. During an interview with LVN 1 on August 26, 2020, LVN 1 stated Resident 1 was a new admission to the facility. LVN 1 stated Resident 1's room was not on droplet precaution isolation. LVN 1 stated, They used to put new admissions on isolation but I guess they aren't anymore. During an interview with the IP on August 26, 2020 at 10:45 AM, the IP stated she had run out of laminated yellow paper to post outside of Resident 1's room. The IP stated the laminated yellow paper was posted to the wall outside a resident's door to indicate droplet precaution isolation. The IP stated an isolation cart should have been placed outside of Resident 1's door and it was not. 1b. A review of Resident 5's face sheet (a document that gives a summary of resident's information), undated, indicated Resident 5 was admitted to the facility on [DATE]. Resident 5 occupied a room on the Yellow Zone Unit (designated to be used and occupied by those residents whose COVID 19 infection status was unknown) of the facility. During an observation of a room on the yellow zone unit on August 26, 2020 at 10:18 AM, a name plate mounted on the wall, next to the room's door, indicated the names of Residents 3, 4 and 5. There was a laminated yellow paper posted on the wall outside the door. The laminated yellow paper was blank. An isolation cart (a cart containing personal protective equipment-PPE-required for entrance into an isolation room) was positioned outside of the room. The cart had three drawers that contained isolation gowns. The door of the room was open and three residents were visualized. Two residents (Residents 3 and 4) were in side by side hospital beds. The third resident (Resident 5) was in a hospital bed across from Residents 3 and 4. The privacy curtains were not drawn between the residents' beds. A Licensed Vocational Nurse (LVN 2) was standing at a medication cart outside the room's door preparing medication. During an interview with LVN 2 on August 26, 2020 at 10:24 AM, LVN 2 stated the room was a droplet precaution isolation room because Resident 5 was a new admission to the facility. LVN 2 stated she had passed medications to Residents 3 and 4 and was preparing medication for Resident 5. LVN 2 stated she had not worn PPE inside the room when she gave Resident 3 and 4 their medication. LVN 2 stated, They (Residents 3 and 4) are not new admissions and they are not sick with COVID 19. I don't wear PPE when I give them their medications. LVN 2 stated she would don (to put on) her PPE when she gave Resident 5 his medication. During an interview with the IP on August 26, 2020 at 10:45 AM, the IP stated Resident 3, 4 and 5's room was a droplet precaution isolation room. The IP stated PPE was to be donned before entering the room, no matter which resident was being cared for. During an interview with the Director of Nursing (DON) on August 26, 2020 at 12:15 PM, the DON stated Resident 1's room should have been marked as a droplet precaution isolation room. The DON stated all staff were to don PPE when entering an isolation room, no matter which resident was being cared for. 2a. A review of Resident 1's face sheet (a document that gives a summary of resident's information), undated, indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 occupied a room on the Yellow Zone Unit (designated to be used and occupied by those residents whose COVID 19 infection status was unknown) of the facility. A review of Resident 2's face sheet (a document that gives a summary of resident's information), undated, indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 occupied a room on the Yellow Zone Unit (designated to be used and occupied by those residents whose COVID 19 infection status was unknown) of the facility. A review of Resident 2's COVID 19 laboratory test result, dated August 20, 2020, indicated a Negative result. During an observation of a room on the yellow zone unit on August 26, 2020 at 10 AM, a name plate mounted on the wall, next to the room's door, indicated the name of Resident 1 and 2. There was no signage outside of the room to indicate droplet precaution isolation. No isolation cart (a cart containing personal protective equipment-PPE-required for entrance into an isolation room) was positioned outside of the room. The door of the room was open and two residents were visualized in side by side hospital beds. The privacy curtain was not drawn between the residents' beds. A Licensed Vocational Nurse (LVN 1) entered the room and checked Resident 1's feeding pump. During an interview with LVN 1 on August 26, 2020, LVN 1 stated Resident 1 was a new admission to the facility and Resident 2 had been in the facility for a few months. During an interview with the Infection Preventionist (IP) on August 26, 2020 at 10:45 AM, the IP stated Resident 1 and 2's room should have had signage indicating it was a droplet precaution isolation room. The IP stated Resident 1 was a new admission and was being monitored for the development of COVID 19 symptoms. The IP stated Resident 2 was not a new admission and had tested negative for the COVID 19 virus. The IP stated it was the facility's policy to place new admissions in private rooms or cohort with other newly admitted residents, but the facility did not have any available rooms. The IP stated, We keep the privacy curtains and door opened because we need to visually monitor the residents. During an observation and interview with a Maintenance Staff (MS), in the presence of the IP, on August 26, 2020 at 11 AM, MS measured the distance between Resident 1 and Resident 2's bed. The MS stated, It's 3 1/2 feet. 2b. A review of Resident 3's face sheet (a document that gives a summary of resident's information), undated,

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) indicated Resident 3 was admitted to the facility on [DATE]. Resident 3 occupied a room on the Yellow Zone Unit (designated to be used and occupied by those residents whose COVID 19 infection status was unknown) of the facility. A review of Resident 3's COVID 19 laboratory test result, dated August 20, 2020, indicated a Negative result. A review of Resident 4's face sheet (a document that gives a summary of resident's information), undated, indicated Resident 4 was admitted to the facility on [DATE]. Resident 4 occupied a room on the Yellow Zone Unit (designated to be used and occupied by those residents whose COVID 19 infection status was unknown) of the facility. A review of Resident 4's COVID 19 laboratory test result, dated August 20, 2020, indicated a Negative result. A review of Resident 5's face sheet (a document that gives a summary of resident's information), undated, indicated Resident 5 was admitted to the facility on [DATE]. Resident 5 occupied a room on the Yellow Zone Unit (designated to be used and occupied by those residents whose COVID 19 infection status was unknown) of the facility. During an observation of a room on the yellow zone unit on August 26, 2020 at 10:18 AM, a name plate mounted on the wall, next to the room's door, indicated the names of Residents 3, 4 and 5. There was a laminated yellow paper posted on the wall outside the door. The laminated yellow paper was blank. An isolation cart (a cart containing personal protective equipment-PPE-required for entrance into an isolation room) was positioned outside of the room. The cart had three drawers that contained isolation gowns. The door of the room was open and three residents were visualized. Two residents (Residents 3 and 4) were in side by side hospital beds. The third resident (Resident 5) was in a hospital bed across from Residents 3 and 4. The privacy curtains were not drawn between the residents' beds. A Licensed Vocational Nurse (LVN 2) was standing at a medication cart outside the room's door preparing medication. During an interview with LVN 2 on August 26, 2020 at 10:24 AM, LVN 2 stated the room was a droplet precaution isolation room because Resident 5 was a new admission to the facility. LVN 2 stated she had passed medications to Residents 3 and 4 and was preparing medication for Resident 5. LVN 2 stated she had not worn PPE inside the room when she gave Resident 3 and 4 their medication. LVN 2 stated, They (Residents 3 and 4) are not new admissions and they are not sick with COVID 19. I don't wear PPE when I give them their medications. LVN 2 stated she would don (to put on) her PPE when she gave Resident 5 his medication. During an interview with the Infection Preventionist (IP) on August 26, 2020 at 10:45 AM, the IP stated Resident 5 was a new admission and was being monitored for the development of COVID 19 symptoms. The IP stated Resident 3 and 4 were not a new admissions and had tested negative for the COVID 19 virus. The IP stated it was the facility's policy to place new admissions in private rooms or cohort with other newly admitted residents, but the facility did not have any available rooms. The IP stated, We keep the privacy curtains and door opened because we need to visually monitor the residents. During an observation and interview with a Maintenance Staff (MS), in the presence of the IP, on August 26, 2020 at 11 AM, MS measured the distance between Resident 5 and Resident 3's bed. The MS stated, It's 42 inches (3 1/2 feet). MS measured the distance between Resident 5 and Resident 4's bed. The MS stated, It's 41 inches (3. 4 feet). During an interview with the Director of Nursing (DON) on August 26, 2020 at 12:15 PM, the DON stated it was the policy of the facility to provide new admissions a private room or cohort with other new admissions, for the 14 day isolation period. The DON stated Residents 1 and 5 were not provided private rooms or cohorted because the facility did not have rooms available. The DON stated the facility did not position Resident 1, 2, 3, 4, and 5's beds six feet apart. The DON stated the privacy curtains were not drawn and the room doors were not closed because the nurses needed to visually monitor the residents. During an interview with the Administrator (Admin) on August 26, 2020 at 12:30 PM, the Admin verified that it was the policy of the facility to provide new admissions a private room or cohort with other new admissions, for the 14 day isolation period. The Admin stated the facility did not have the rooms available to comply with the policy. A review of the facility's policy and procedure titled, Admission of a Resident, dated March 2020, indicated the following: 13. ADMISSION PROCESS DURING COVID-19 PANDEMIC a. The Admission Process above will be followed, in addition to the following precautions. b. Facility will follow CDC (Centers for Disease Control) precautions regarding admission of residents into a SNF (Skilled Nursing Facility). c. A new admission who has a positive Covid test result from the referring hospital will be admitted into the Covid Unit/Red Zone of the facility. d. New admissions that have not been tested for Covid-19 in the previous 7- days will be treated as a Person Under Investigation (PUI.) Isolation precautions will be implemented. Efforts will be made to cohort the patient with other PUI's. Isolation precautions will remain in place for 14-days. e. Patients being admitted to the facility who have tested negative for Covid-19 in the previous 7-days will not be placed on isolation precautions.