STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056183	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALLEY HEALTHCARE CENTER	1680 NORTH 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 74 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, and 4, when a Licensed Vocational Nurse (LVN 1) failed to wear a gown, a Licensed Vocational Nurse (LVN 2) failed to wear goggles or a face shield and Laundry Staff (LS) failed to wear a gown and goggles or a face shield 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, gloves, and goggles or face shield while in the patient's room). 2. A Licensed Vocational Nurse (LVN 3) on the Red Zone Unit (designated to be used and occupied by those residents who had tested positive for the COVID 19 virus) disinfected her face shield with a disinfectant that was not an EPA (Environmental Protection Agency)-registered disinfectant qualified for use against [DIAGNOSES REDACTED]-COV-2 (COVID 19). 3. The facility did not develop and implement a procedure that applied CDC (Centers for Disease Control) guidance on the limited re-use of N 95 respirators (a particulate-filtering face piece respirator-mask-that filters at least 95% of airborne particles). These failures had the potential to cause an infection to spread to other residents of the facility. Findings: During an interview with the Administrator (Admin) on July 29, 2020 at 10:20 AM, the Admin stated the facility had been broken up into two units: the yellow zone unit and the red zone unit. The yellow zone was for residents who had been exposed to COVID 19 and the residents on the yellow zone unit had been placed on droplet precaution isolation. The Admin stated the red zone was for residents who tested positive for COVID 19 and the residents on the red zone unit had been placed on droplet precaution isolation. The Admin stated the facility did not have a green zone unit (designated to be used and occupied by those residents who had tested negative for the COVID 19 virus) at this time because after July 4, 2020, the facility had experienced multiple positive cases of COVID 19 throughout the facility, so the facility considered all of their residents as exposed. 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 who were exposed to COVID 19 but their infection status was unknown) of the facility. Resident 1 had been placed on droplet precaution isolation due to COVID 19 exposure). 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 who were exposed to COVID 19 but their infection status was unknown) of the facility. Resident 2 had been placed on droplet precaution isolation due to COVID 19 exposure). During an observation of a room on the yellow zone unit on July 29, 2020, at 10:46 AM, a name plate mounted on the wall, next to the room's door, indicated the names of Residents 1 and 2. A small blue paper sign affixed to door jamb indicated, PPE (personal protection equipment) required. Gloves, Mask, Gown. Two yellow colored paper signs affixed to wall beside the door indicated: Sign 1, Yellow Zone, PPE Required in Hallway at all times-N-95 Mask and eye protection, Sign 2, Yellow Zone, PPE required during patient care, N-95 Mask, eye protection, gloves, gown. Two additional sign were posted showing a demonstration of how to don (to put on) and doff (to take off) PPE. An isolation cart was positioned outside the room. The top drawer contained gloves, blood pressure cuff and a stethoscope. The second drawer contained blue plastic sheeting. The third drawer contained disposable gowns. The cart did not contain goggles, face shields, N95 masks or surgical masks. A hand sanitizing dispenser was mounted on the wall of Resident 1 and 2's room. During an observation of a Licensed Vocational Nurse (LVN 1) and a Licensed Vocational Nurse (LVN 2) on July 29, 2020, at 11:04 AM, LVN 1 and LVN 2 stood at a medication cart outside of Resident 1 and 2's room. LVN 1 and LVN 2 worked together and prepared medications for Resident 1 and 2. LVN 2 held a medication cup and walked into Resident 1 and 2's room. LVN 2 had on a gown, gloves, mask and eye glasses. LVN 2 did not wear goggles or a face shield. LVN 1 walked into Resident 1 and 2's room and followed behind LVN 2. LVN 1 had on a mask and goggles. LVN 1 did not wear a gown. LVN 1 and LVN 2 stood next to each other next to Resident 2's bed. LVN 2 handed Resident 2 the pill cup. Resident 2 took the pill cup. During an interview with LVN 1 and LVN 2 on July 29, 2020, at 11:08 AM, LVN 1 stated she was training LVN 2. LVN 1 stated she did not wear a gown inside Resident 1 and 2's room because she did not touch anything. LVN 2 stated she did not wear eye protection in Resident 1 and 2's room because the goggles did not fit over her glasses. LVN 2 stated, Do my eyeglasses protect my eyes? 1b. A review of Resident 3's face sheet (a document that gives a summary of resident's information), undated, 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 who were exposed to COVID 19 but their infection status was unknown) of the facility. Resident 3 had been placed on droplet precaution isolation due to COVID 19 exposure). 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 who were exposed to COVID 19 but their infection status was unknown) of the facility. Resident 4 had been placed on droplet precaution isolation due to COVID 19 exposure). During an observation of a room on the yellow zone unit on July 29, 2020 at 11:12 AM, a name plate mounted on the wall, next to the room's door, indicated the names of Residents 3 and 4. There was no signage on the wall next to the door, on the door jamb or on the door that indicated Resident 3 and 4's room was on the yellow zone unit or that droplet precaution isolation was in effect. There was no isolation cart positioned outside of Resident 3 and 4's room. During an observation and interview of a Laundry Staff (LS) on July 29, 202,0 at 11:18 AM, LS was seen standing inside Resident 3 and 4's room. LS was wearing a mask. LS did not have on a gown, gloves or eye protection. LS stated she had brought up clean clothes from the laundry for Resident 3 and 4 and she had been hanging the clothes up in Resident 3 and 4's room. LS stated I don't have to wear a face shield or gown because this room is not a yellow zone room. There are no yellow signs next to it. During an interview with the Admin and Director of Nursing/Infection Preventionist (DON/IP 1) on July 29, 2020, at 1:08 PM, the Admin stated Residents 1, 2, 3, and 4's rooms were on the yellow zone unit and all four residents had been placed on droplet precaution isolation. The Admin stated it was his expectation that all staff follow the directions indicated on the yellow signage posted throughout the yellow zone unit. The DON/IP 1 stated she was the Infection Preventionist for the yellow zone unit. The DON/IP 1 stated she expected all staff to follow the directions indicated on the yellow signage. A review of the facility's policy and procedure titled, Heaton Resources: Infection Prevention and Control for COVID-19, dated March 2020, indicated the following: Transmission: .transmission most commonly occurs during close exposure to a person infected with COVID-19. The primary route of transmission appears to be via respiratory droplets produced when an infected person coughs or sneezes. Droplets can land in the mouth, nose, or eyes of people who are nearby or possibly be inhaled into the lungs of those within close proximity. Droplet Precautions: Droplet precautions are implemented to control the spread of infections by droplets through short distances in the air. Droplets are large particles (greater than 5 microns-a unit of measure) that

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** - Many	(continued... from page 1) can be inhaled when an infected person coughs, sneezes or talks .Masks, gowns, gloves and goggles should be worn during procedures that expose healthcare personnel to splashes or sprays of secretions. A review of the facility's policy and procedure titled Personal Protective Equipment - Using Protective Eyewear, dated September 2010, indicated the following: Objectives: .To protect the employee's eyes, nose, and mouth from potentially infectious materials. Miscellaneous: .eye protection devices, such as goggles or glasses with solid side shields or chin-length face shields, shall be worn together whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be expected. Personal eyeglasses should not be considered as adequate protective eyewear. Protective eyewear must have adequate side and top coverage and must fit the employee properly. 2. During an observation and interview with a Licensed Vocational Nurse (LVN 3) on July 29, 2020 at 12:30 PM, LVN 3 stated she was a treatment nurse (a nurse who provided wound care treatments for residents) who was assigned to work only on the facility's Red Zone Unit (designated to be used and occupied by those residents who tested positive for the COVID 19 virus). LVN 3 demonstrated how she doffed (to take off) her PPE (Personal Protective Equipment). LVN 3 stated she doffed her PPE by the Red Zone Unit's exit door. LVN 3 stated she would remove her gloves and discard them in the trash can. LVN 3 stated she would remove her gown and put it in the trash can if it was disposable or into the dirty linen bin if it was reusable. LVN 3 stated she would use ABHR (alcohol based hand rub) to clean her hands. LVN 3 stated she would remove her face shield, clean it with 70 percent alcohol swabs and store it in her locker for reuse. LVN 3 stated she would use ABHR again to clean her hands. LVN 3 stated she would then discard her N95 mask in the trash and leave through the exit door. LVN 3 stated the facility had trained her to use bleach wipes to clean her face shield but she did not like bleach that close to her face so she chose to use the 70 percent alcohol swabs instead. During an interview with an Infection Preventionist (IP 2) on July 29, 2020 at 12:50 PM, IP 2 stated she was the Infection Preventionist in charge of the Red Zone Unit. IP 2 stated staff were taught to disinfect their face shields with bleach wipes. IP 2 stated it was okay for staff to use 70 percent alcohol swabs to disinfect their face shields if they wanted to. During an interview with the Administrator (Admin) and Director of Nursing/Infection Preventionist (DON/IP 1) on July 29, 2020 at 1:08 PM, the Admin and DON/IP 1 stated a policy and procedure that indicated a facility approved procedure for disinfecting PPE had not been developed. The Admin and DON/IP 1 stated the face shield should not be disinfected with 70 percent alcohol swabs, a disinfectant approved by the EPA (Environmental Protection Agency) to kill COVID 19 should be used. The facility did not provide a policy and procedure indicating the procedure to disinfect face shields or goggles for re-use. 3. During an observation and interview with a Licensed Vocational Nurse (LVN 3) on July 29, 2020 at 12:30 PM, LVN 3 stated she was a treatment nurse (a nurse who provided wound care treatments for residents) who was assigned to work only on the facility's Red Zone Unit (designated to be used and occupied by those residents who tested positive for the COVID 19 virus). LVN 3 demonstrated how she doffed (to take off) her PPE (Personal Protective Equipment). LVN 3 stated she doffed her PPE by the Red Zone Unit's exit door. LVN 3 stated she would remove her gloves and discard them in the trash can. LVN 3 stated she would remove her gown and put it in the trash can if it was disposable or into the dirty linen bin if it was reusable. LVN 3 stated she would use ABHR (alcohol based hand rub) to clean her hands. LVN 3 stated she would remove her face shield, clean it with 70 percent alcohol swabs and store it in her locker for reuse. LVN 3 stated she would use ABHR again to clean her hands. LVN 3 stated she would then discard her N95 mask in the trash and leave through the exit door. LVN 3 stated the facility had trained her how to re-use her N 95 mask back in March 2020 when supplies were low. LVN 3 stated at the end of her shift she would place the N 95 mask in a plastic zip lock bag and store it in her locker. LVN 3 stated she would remove the N 95 from its plastic zip lock bag the next day and reuse it. LVN 3 stated she would do this procedure two to three times and then throw the N 95 mask away and get a new one. During an interview with an Infection Preventionist (IP 2) on July 29, 2020 at 12:50 PM, IP 2 stated she was the Infection Preventionist in charge of the Red Zone Unit. IP 2 stated staff had been taught to reuse their N 95 masks by storing them in a plastic zip lock bag and then re-using them the next day. During an interview with the Administrator (Admin) and Director of Nursing/Infection Preventionist (DON/IP 1) on July 29, 2020 at 1:08 PM, the Admin and DON/IP 1 stated a policy and procedure that indicated a facility approved procedure for the re-use of N 95 masks had not been developed. The Admin and DON/IP 1 stated the facility looked to CDC (Centers for Disease Control) guidance in the development of its infection control policies and procedures. The facility did not provide a policy and procedure indicating the procedure for the limited re-use of N 95 masks.