STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555630	A. BUILDING _____ B. WING _____	**06/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HILLCREST HEIGHTS HEALTHCARE CENTER	**4033 SIXTH AVENUE EXT SAN DIEGO, CA 92103**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during a COVID- 19 (respiratory illness caused by coronavirus) survey, the facility failed to ensure: - Nursing staff consistently wore masks while in resident areas. - Nursing staff performed hand hygiene after providing care to residents (Residents 2 and 3). - Nursing staff disinfected medical equipment after use. These deficient practices had the potential to spread disease and infection amongst residents and staff. Findings: Resident 2 was admitted to the facility on [DATE], per the facility's Admission Record. Resident 3 was admitted to the facility on [DATE], per the facility's Admission Record. On 6/12/20 at 11:35 A.M., an observation was conducted. Certified Nursing Assistant (CNA) 1 was observed leaving a resident's room. CNA 1 was wearing a surgical mask around her neck. CNA 1's nose and mouth were exposed while she walked down the hall, and while speaking to other staff. Several residents were also observed concurrently in the hall, and some of those residents did not have facial coverings. On 6/12/20 at 11:36 A.M., a concurrent observation and interview was conducted with CNA 1 and the facility's administrator (ADM). CNA 1 was observed with her surgical mask around her neck. CNA 1 stated, It fell down. The ADM stated it was her expectation for all staff to wear a surgical mask that covered both the nose and mouth while inside the building. On 6/12/20 at 11:40 A.M., an observation was conducted. Licensed nurse (LN) 2 was observed completing a blood glucose reading (a blood draw done to determine how much glucose is in a person's blood) for Resident 2. LN 2 removed his gloves. LN 2 did not perform hand hygiene (wash hands or use hand sanitizer). LN 2 recorded the blood glucose level on a paper chart. LN 2 went to the nursing station to dispose of something. LN 2 did not perform hand hygiene. LN 2 went back to his medication cart and retrieved an electronic blood pressure cuff (medical equipment placed over a person's extremity to take a blood pressure reading), and went into Resident 3's room. LN 2 did not perform hand hygiene. LN 2 used the electronic blood pressure cuff on Resident 3's arm. LN 2 came out of Resident 3's room and wrote something down on the paper chart at at the medication cart. LN 2 did not perform hand hygiene. LN 2 retrieved a temporal thermometer (medical equipment that reads a person's temperature when placed against the forehead area), and went into Resident 3's room. LN 2 did not perform hand hygiene. LN 2 took Resident 3's temperature, wrote it down on paper, and returned to his medication cart. LN 2 did not perform hand hygiene. LN 2 put the electronic blood pressure cuff and temporal thermometer into the drawer of the medication cart. LN 2 did not disinfect the electronic blood pressure cuff or temporal thermometer after use on Resident 3. LN 2 brought a medication card up to the nursing station, and then went to the computer alcove to access the computer. LN 2 did not perform hand hygiene. On 6/12/20 at 11:59 A.M., an observation and interview was conducted with LN 1. LN 1 was observed walking through the hall with no mask or facial covering. Other staff and residents were also in the hall. LN 1 went to the nursing station, acquired a surgical mask, and put it on. LN 1 stated she had returned from her lunch break and forgot her mask in the car. LN 1 stated she walked through resident care areas without covering her nose and mouth. LN 1 stated all staff were required to wear a surgical mask while inside the building. LN 1 stated she should not have entered the building without wearing a surgical mask. On 6/12/20 at 12:05 P.M., an interview was conducted with LN 2. LN 2 stated he did not perform hand hygiene after taking Resident 2's blood glucose reading. LN 2 stated he should have. LN 2 stated he did not perform hand hygiene prior to, or after, taking Resident 3's blood pressure and temperature reading. LN 2 stated he should have. LN 2 stated nurses were supposed to perform hand hygiene prior to providing care to a resident, after providing care to a resident, and in between tasks. LN 2 stated he had forgotten. LN 2 further stated medical equipment was supposed to be disinfected immediately after resident use. LN 2 stated he should not have put the electronic blood pressure cuff and temporal thermometer away before disinfecting them. On 6/12/20 at 12:15 P.M., an interview was conducted with the facility's infection preventionist (IP). The IP stated all staff were required to wear a surgical mask that covered both nose and mouth while inside the building. The IP stated it was her expectation that nursing staff performed hand hygiene before and after providing care to a resident and after completing tasks. The IP stated medical equipment had to be cleaned and disinfected after use and before putting it away. On 6/12/20 at 12:45 P.M., a joint interview was conducted with the ADM and director of nursing (DON). The DON stated CNA 1 and LN 1 should have been wearing a mask, and wearing it correctly to cover both nose and mouth while inside of the building. The DON stated LN 2 should have performed hand hygiene after providing care to Resident 2 and before providing care to Resident 3. The DON stated it was her expectation for medical equipment such as blood pressure cuffs and thermometers to be cleaned and disinfected immediately after resident use. Per the facility's policy titled, Infection Prevention and Control: Novel Coronavirus (COVID -19), revised 6/9/20, .5. The facility will re-educate and reinforce: Strong hand hygiene practices . Implementation of Universal Masking Protocol . Proper mask use and hygiene, including wearing the facemask as directed to cover the mouth and nose . The policy did not provide guidance for disinfecting medical equipment after use.

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