STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555765	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE HILLS POST ACUTE	1800 OLD TUSTIN ROAD SANTA ANA, CA 92705

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** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure each staff had their own gown when required for entering a resident's room who was in isolation. Several staff members were sharing one gown to provide care to residents on contact and droplet precautions. * LVN 1 placed a used gown in a PPE cart intended to store clean PPE. * The Maintenance Director doffed his reusable gown (shared by several staff) while still wearing potentially contaminated gloves. * A CNA failed to perform hand hygiene after removing her gloves and prior to exiting a resident's room on contact and droplet precaution. These failures had the potential for cross-contamination and spread of infectious organisms in the facility. Findings: 1a. Review of the facility's P&P titled Personal Protective Equipment Conservation During Crisis or Pandemic Policy revised 4/15/2020, showed the use of PPE during the performance of patient care and routine facility tasks is to prevent exposure to or transmission of actual or potential sources of infectious organisms to patients and staff. During a crisis or pandemic event, conservation methods and strategies to obtain or maintain capacity may be enacted to ensure PPE supplies are used efficiently and according to the recommended circumstances while also affording the facility the criteria to implement strategies for extended use and re-use as appropriate. Further review of the facility's P&P showed both extended use and re-use is defined as the practice of using the same piece of protective equipment by one healthcare worker for multiple encounters. On 7/16/2020 at 0935 hours, an interview was conducted with the DON. The DON stated resident rooms with a yellow sign by the entrance identified the room was on contact and droplet precautions. The DON stated any persons entering the room was required to wear the appropriate PPE, including a gown, face mask, gloves and goggles or a face shield if required. On 7/16/2020 at 0957 hours, a yellow contact and droplet precautions sign was observed posted by the entrance of Resident C's room. A washable gown was observed hanging on a hook outside the closed door. A PPE cart was observed by the entrance of the room but did not contain any gowns. b. On 7/16/2020 at 1016 hours, a yellow contact and droplet precautions sign was observed posted by the entrance of Resident D's room. A washable gown was observed hanging on a hook on the closed door. A PPE cart observed by the entrance of the room contained two boxes of gloves but did not contain any gowns. On 7/16/2020 at 1024 hours, an interview was conducted with CNA 1. CNA 1 stated the gown hanging on Resident D's door was used. CNA 1 stated the gown hanging on the door would be reused by both the CNA and licensed nurse until it was collected by housekeeping for washing. c. On 7/16/2020 at 1044 hours, a yellow contact and droplet precautions sign was observed posted by the entrance of Resident E's room. A washable gown was observed hanging on a hook on the closed door. A PPE cart observed by the entrance of the room did not contain any gowns. On 7/16/2020 at 1044 hours, an interview was conducted with CNA 2. CNA 2 stated the one gown hanging on Resident E's door was being reused and shared by several staff who entered the room to care for Resident E. CNA 2 stated the staff shared that one gown until it was replaced by housekeeping. CNA 2 stated housekeeping would collect all the used gowns hanging on the residents' doors every few hours and replace them with clean, washed gowns. CNA 2 verified the PPE cart by the entrance of Resident E's room did not contain any clean gowns. On 7/16/2020 at 1048 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated each resident room on the Yellow Zone was on contact and droplet precautions and given one clean washable gown every four hours; the gown was shared by all staff who entered the room. The Maintenance Director stated the staff would place the gown on the hook on the door after they were done providing care to the resident and the next staff entering the room would reuse the same gown. On 7/16/2020 at 1053 hours, an interview was conducted with LVN 2. LVN 2 was asked what gown he would use when entering Resident E's room. LVN 2 stated he would don the gown that was hanging on the hook of Resident E's door. LVN 2 stated he shared that gown with the CNA assigned to Resident E. d. On 7/16/2020 at 1102 hours, CNA 3 was observed in Resident F's room. Resident F had a yellow contact and droplet precautions sign posted by the entrance of her room. Clean gowns were not observed available in the PPE cart located at the entrance of Resident F's room. After removing her gloves and performing hand hygiene, CNA 3 was observed removing her gown and hanging the gown on the hook of Resident F's door. CNA 3 was asked why she hung the gown. CNA 3 stated she hung the gown so she or the nurse could reuse the gown if they needed to enter Resident F's room. CNA 3 verified there were no clean gowns in the PPE cart by Resident F's room. On 7/16/2020 at 1108 hours, an interview was conducted with LVN 3. LVN 3 was asked what gown she would use when entering Resident F's room. LVN 2 stated she would don the gown that was hanging on the hook of Resident F's door. On 7/16/2020 at 1114 hours, an interview was conducted with the Administrator. The Administrator stated gowns were being reused for residents on contact and droplet precautions; a new clean gown was provided every four hours. The Administrator verified the one gown was shared by several staff until it was collected for washing. 2. On 7/16/2020 at 1016 hours, a yellow contact and droplet precautions sign was observed posted by the entrance of Resident D's room. A washable gown was observed hanging on a hook on the closed door. A PPE cart observed by the entrance of the room contained two boxes of gloves but did not contain any gowns. On 7/16/2020 at 1019 hours, an interview was conducted with LVN 1. LVN 1 was asked if the gown hanging on the hook of Resident D's door was clean. LVN 1 stated he was unsure. LVN 1 proceeded to take the gown off of the hook, rolled the gown up into a bundle, and placed it in the PPE cart, intended to store clean PPE. On 7/16/2020 at 1127 hours, an interview was conducted with the facility's Infection Preventionist. The Infection Preventionist stated gowns hung on the hooks of residents' doors were used and not supposed to be placed in the PPE cart. On 7/17/2020 at 1015 hours, a telephone interview was conducted with Physician 1, an infectious disease specialist at the Orange County Healthcare Agency (county public health). Physician 1 stated the staff were not supposed to share PPE; he stated when multiple staff shared a gown, there was a potential for cross-contamination. 3. Review of the facility's P&P titled How to Safely Remove Personal Protective Equipment (undated) showed to remove PPE in the following sequence: apply gloves (outside of gloves are contaminated), don on goggles or face shield, don on gown (gown front and sleeves are contaminated), then don on a mask or respirator and finally perform hand hygiene using soap and water or use an alcohol-based hand sanitizer immediately after removing all PPE. On 7/16/20 at 1030 hours, during an observation of the Maintenance Director, the following was identified: - The Maintenance Director came to Resident A's room, which was marked as a yellow room and would require the staff to put on the PPE (mask, face shield or goggle, gown, and gloves) as evidenced by the sign posted outside the resident's room. There was a mobile cart containing gloves and a hand sanitizer station outside Resident A's room. - The Maintenance Director was observed wearing a mask. The Maintenance Director put on a pair of gloves and donned a gown hanging outside Resident A's room. - The Maintenance Director then went to Resident A's bedside. The Maintenance Director used the bed control to raise Resident A's bed and opened up the privacy curtain. The Maintenance Director then moved Resident A's dresser and bed. - After assisting Resident A, the Maintenance Director untied his gown at the neck and waist area with his gloved hands. The Maintenance Director, without removing his used gloves, took off his gown by holding the collar portion of the gown and then hung it by the door. The Maintenance Director then took off

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** - Some	(continued... from page 1) his gloves and tossed them in a trash bin. On 7/16/20 at 1033 hours, an interview was conducted with the Maintenance Director. When asked about the sequence of donning and doffing of PPE, the Maintenance Director stated when exiting the yellow room he had to remove his gown first, hung it by the door for reuse, then remove his gloves last. The Maintenance Director stated he had received training for PPE use. On 7/16/20 at 1200 hours, during an interview with the Infection Preventionist, she stated the process to remove PPE upon exiting the yellow zone was to remove gloves first prior to other pieces because they were the dirtiest piece of PPE. 4. On 7/16/20 at 1042 hours, during an observation of CNA 4 in Resident B's room, which was marked a yellow room. CNA 4 was in the room and wearing a mask, a face shield, a gown, and gloves. CNA 4 helped button up Resident B's blouse, made her bed, folded her laundry, emptied the two trash bins (one from the restroom and one by the resident's bed) took out the plastic trash bags, and placed them on the floor by the door. After providing assistance to Resident B, CNA 4 removed her gloves, the face shield, and gown. However, CNA 4 did not perform hand hygiene. CNA 4 picked up the trash bags off the floor with her bare hands, walked out of Resident B's room to across the hallway to the communal shower room. CNA 4 held and propped the shower room door and tossed the trash bags into a big trash bin. On 7/16/20 at 1052 hours,an interview was conducted with CNA 4. When asked about hand hygiene requirements after the removal of PPE CNA 4 stated she forgot to perform hand hygiene after removing her gloves. On 7/16/20 at 12 hours, during an interview with the facility's Infection Preventionist, she stated CNA 4 should have immediately performed hand hygiene after removing her PPE and before going to another area.