STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A164	A. BUILDING _____ B. WING _____	**09/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
OLIVE VISTA BEHAVIORAL HEALTH CENTER	**2335 S TOWNE AVENUE POMONA, CA 91766**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 8/27/2020 at 2 p.m., an announced visit was conducted at the facility to investigate complaints regarding infection control. Based on observation, interview and record review, the facility failed to prevent the spread of infection by failing to: 1. Ensure the [MEDICATION NAME] thermometer scanner (a device used to measure a person's temperature from a distance) was disinfected or sanitized after each use. The staff positioned the scanner in close distance risking the spread of [MEDICAL CONDITION]/disease between person to person use. 2. Reinforce physical distancing among residents during smoke break. 3. Ensure staff do not allow residents to have water self-serviced if spout is not sanitized with every use due to possible cross contamination 4. Ensure licensed nurses assigned to care for confirmed COVID-19 (Coronavirus disease, a severe respiratory illness caused by virus and spread from person to person) residents (Residents 1, 2, and 3), are not assigned to residents who are symptomatic/suspected/quarantined/ and negative COVID-19 residents at the same time. 5. Ensure staff follow the proper sequence for donning (putting on) and doffing (taking off) personal protective equipment (PPE- gown, gloves, mask and face shield) before and after providing care to the residents. 6. Ensure that the red zone area (area for residents who tested positive for COVID-19) had dedicated cleaning supplies stored in a supply cart. These deficient practices had the potential in further spread of COVID-19 to other residents and staff. Findings: 1. During observation on 8/27/2020, at 2:20 p.m., a facility staff performed the screening health process to the surveyors that included screening questions, assessment of illness and temperature check. Elevated (High) temperature reading can be a sign and symptom of the COVID-19 illness. Staff placed the [MEDICATION NAME] temperature scanner in closed contact to the person's forehead or skin and failed to sanitize the thermometer scanner after each use. During an interview with the staff on 8/27/2020, at 2: 30 p.m., she stated the thermometer scanner did not have to be cleansed because it did not touch the person's skin or forehead. 2. During a general observation on 8/27/2020, at 3:28 p.m., at the outside patio connecting the East and South Stations, 10 residents were observed in line to get their cigarettes and not social distancing (6 ft apart). There were 2 staffs present assisting residents. This was pointed out to the director of nursing (DON), who stated staffs should have been monitored and reminded to be six feet away from each other. DON also stated that staffs should be aware of the policy regarding social distancing. 3. During the same general observation on 8/27/2020, at 3:30 p.m., two orange colored 10- gallon water containers were observed in East and South Nursing Stations. During a concurrent interview with the IP, he stated that those water are for the residents to help themselves (self-service) if they need water. The IP also stated that the spout has to be cleaned or sanitized by the staff after each resident touches it. The IP stated that those containers will be removed immediately. 4. During a tour of the East Nursing Station and a concurrent interview on 8/27/2020, at 3:33 p.m., licensed vocational nurse (LVN) 1 stated she was the only charge nurse for the unit that had the green (area for residents believed to have been unexposed to COVID-19), yellow (area for persons with undetermined illness) and red zones. She added that she was the one that administered all the afternoon medications for all the residents. LVN 1 stated she will administer medications to residents in the green, followed by the residents in the yellow zones and lastly the residents in the red zone. LVN 1 stated that she had the proper PPE (gowns, gloves and face shields) when she entered the yellow and red zones. On 8/27/2020, at 3:45 p.m., during an interview with the director of nursing (DON), she stated that one LVN was in charge of the unit as long as the LVN administers the medications last in the red zone with the appropriate PPE on. A review of the facility's Mitigation Plan (MP, a plan to reduce loss of life and impact of COVID-19 in the facility) under section Cohorting Policies, indicated for the facility to Staff them separately, across all shifts and all job functions. A review of the Centers for Disease Control and Prevention (CDC) guidance for Preparing for COVID-19 in Nursing Homes updated June 25, 2020, indicated to identify space in the facility that could be dedicated to care for residents with confirmed COVID-19 and identify health care personnel (HCP) who will be assigned to work only on the COVID-19 care unit when it is in use. 5. On 8/27/20, at 3:50 p.m., during an observation of staff's return demonstration of proper donning/doffing of PPE, LVN 1 was observed to don her gloves over the cuff of her disposable gown and then removing the gown prior to removing her soiled gloves. LVN 1 stated she was supposed to take off her gloves before removing her gown. On 8/27/2020, at 3:58 p.m., during an interview, Infection Preventionist (IP- individual responsible for infection prevention and control (IPC) programs in nursing homes) stated LVN 1 is supposed to remove their PPE's in the proper order - remove the gloves, gown, hand hygiene, then face shield/goggles. A review of the facility's Mitigation Plan (MP), signed 5/7/2020, indicated: How To Take Off (Doff) PPE Gear: 1. Remove gloves, 2. Remove gown, 3. May exit the room, 4. Perform hand hygiene, 5. Remove face shield or goggles, 6. Remove mask and 7. Perform hand hygiene. 6. On 8/27/2020, at 4 p.m., a tour/observation of the facility's red zone was conducted with the DON and IP. During this tour, the DON was asked regarding cleaning supplies used for the red zone. DON looked around and did not find the cleaning supplies for red zone. During the observation, the facility did not have the cleaning supplies/cart dedicated for the red zone. Not having a dedicated cleaning supplies for the zones can create a potential for cross contamination (the transfer of virus or other microorganisms from one substance to another). According to the CDC guidelines for Environmental Infection Control for the Coronavirus Disease 2019 (COVID-19), Ensure shared or non-dedicated equipment is cleaned and disinfected after use according to the manufacturer's recommendations.

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.