STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056023	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVALON VILLA CARE CENTER	12029 AVALON BLVD LOS ANGELES, CA 90061

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 record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development, transmission of communicable diseases, and infections by following infection control guidelines, and implement recommendations by the Public Health Nurse (PHN) to prevent and reduce transmission of COVID-19 (a highly infectious respiratory disease) by; a. Posting appropriate signage as per public health recommendations to remind staff to close the resident's doors who are housed in the quarantine (are public health practices used to protect the public by preventing exposure to people who have or may have a contagious disease) unit, b. Ensuring the resident's doors were closed in the quarantine unit, c. Ensuring staff received continued training and follow up on how to don (put on) and doff (take off) the isolation gowns and masks to reduce the risk of contamination and transmission of COVID-19, d. Providing personal protective equipment ((PPE) equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) training in a timely manner per recommendations by previous visits made by the PHN and, e. Assigning designated staff to quarantine unit to reduce the risk of cross-contamination (process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). These deficient practices had the potential for increased risk in the transmission of COVID-19 among he residents, staff, and the community. Findings: During an observation on 8/21/20 at 9:56 a.m., one of the staff members was standing at the nurse station with their mask tucked below their nose. During an observation and interview on 8/21/20 at 10:00 a.m., the Activity Supervisor (AS), who was wearing a blue isolation gown, assisted a resident in his wheelchair through the plastic barrier (obstacle that prevents movement) from the quarantine (separate and prevent movement) unit to the non-COVID-19 unit. During a concurrent interview AS stated the plastic barrier was the only entrance and exit to the quarantine unit. There was two residents from the quarantine unit observed on the smoking patio. During a concurrent interview with the Activity Aide (AA) stated the quarantine unit residents were scheduled to smoke at 10:00 a.m. and non-COVID-19 unit residents were scheduled at 11 a.m., 2 p.m. and 5 p.m. The AA stated the non-COVID-19 and quarantine unit residents were not grouped together on the patio together. The AA stated she was part-time and was assigned to the patio and moved between the quarantine unit and non-COVID-19 unit residents. The AA stated the quarantine barrier was used to transfer the resident out to the patio. AA stated there were frequent in-services for PPE donning and doffing by the infection preventionist. During an observation of the smoking patio, the two residents from the quarantine unit returned to their rooms through the plastic barrier by the AA, who unzipped the barrier and rezipped it after assisting residents. The AA doffed her gloves, untied the back tie behind her neck, and shifted the gown completely around her waist, with the front of the gown at her backside and the tie was in front by the stomach. The AA proceeded to untie the gown and potentially contaminated herself when doffing. The AA stated, I have to go to the green unit now. A review of the Sequence of Donning and Doffing PPE form indicated last PPE training conducted for AA was on 4/16/20. The inservice form was not dated but indicated there was a check marks for second review of PPE procedures. A review of the undated Lesson Plan for PPE indicated the teaching method used was lecture and role playing. The Lesson Plan did not include inspection of demonstrating actual donning and doffing. During an observation on 8/21/20 at 10:22 a.m., there were a total of 8 residents housed in the quarantine unit. Three resident room doors were open, two of the rooms housed two to three residents. There was no signage posted to remind the staff to keep doors closed in quarantine zone. To access the isolation unit, staff walked through the hall of the quarantine unit and passed a quarantine room. During a concurrent interview, the Licensed Vocational Nurse (LVN 2) stated the entrance and exit for the quarantine unit was through the plastic barriers. LVN 2 stated the staff entered the isolation unit from the facility's back door. LVN 2 stated We just leave the doors open in the quarantine unit unless they are persons under investigation (PUIs). During an observation and interview 8/21/20 at 10:27 a.m., Medical Records (MR) unzipped the quarantine plastic barriers, entered half way into the unit without wearing a gown and immediately went back out, zipped the barrier shut, and then unzipped the plastic barrier and entered the unit with an isolation gown. During a concurrent interview when asked why they came in and then left the MR stated, I am supposed to wear a gown in the quarantine unit, according to the IP nurse and I needed to put one on. During an observation a Certified Nurse Assistant (CNA 2) disposed a trash bag in a yellow barrel marked soiled, closed the lid, went to a resident room, donned a blue gown and entered room to assist the resident, without performing performing hand hygiene (applying an alcohol-based handrub to the surface of hands or washing hands with the use of a water and soap or a soap solution, either non-antimicrobial or antimicrobial). During a concurrent interview CNA 2 acknowledged before entering a resident room, the staff had to put on a gown and wear an N95 and or surgical mask. CNA 2 stated hands should be washed prior to putting on gloves and caring for the resident. CNA 2 stated she understood what happened and that hand hygiene was important to prevent the risk of contamination. During an interview on 8/21/20 at 12:19 p.m., the Licensed Vocational Nurse (LVN 1) stated We don't have scheduled staff in-services. LVN 1 stated she utilized videos from CDC or fliers to teach staff. LVN 1 stated, I don't have the staff show me how to put on the PPE, I have them state how to don and doff PPEs. LVN 1 stated that return demonstration for PPEs was only done for the staff working in the quarantine and isolation zones. LVN 1 stated that she did not want to use too many PPEs. LVN 1 stated the facility was not short on PPEs. LVN 1 stated that auditing was completed for staff on hand hygiene, but she did not audit donning and doffing of PPEs or the masks. LVN 1 acknowledged she understood that it was important to ensure staff were properly performing these tasks. During an interview on 8/21/20 at 12:50 p.m., the Director of Nursing (DON) expressed the importance to have face mask covering the nose in terms of infection source control. During an observation upon exiting the facility through the non-COVID-19 unit, three staff members who were standing at the nurse station wore their face masks tucked under their noses. During an interview on 8/26/20 at 10:15 a.m., LVN 1 stated she had been in the IP role since 12/2019 and received training from the previous IP. LVN 1 stated,There is a policy book and basically went by that. LVN 1 stated her role consisted of infection control for COVID-19, which included testing of the residents and staff members. LVN 1 stated the responsibilities included training the all the departments, including activities, housekeeping, and the kitchen staff. LVN 1 stated two in-services had been completed for PPEs. LVN 1 stated an in-service would be performed when issues arise. When asked how she would know if an issue existed if auditing was not being done, LVN 1 stated, I don't and haven't done audits for PPE or masking. LVN 1 stated she did conducted frequent checks on staff, but no documented evidence was provided. LVN 1 stated she kept current on COVID-19 by going to the website to read the updates every day. LVN 1 stated in the quarantine unit staff should be wearing full PPEs, an N95 (particulate-filtering facepiece respirator) mask, surgical mask, and face. LVN 1 stated the staff must wear face shield and use a different gown for each resident. LVN 1 stated the doors in the quarantine unit should be closed for persons under investigation who are symptomatic without COVID-19 testing. LVN 1 stated, The only time the doors are closed in the quarantine unit is if the resident is symptomatic. LVN 1 stated training was done on proper use of masks and staff were to wear and N95 with a surgical mask on top. LVN 1 stated the mask should cover the nose and mouth. When asked if auditing was done for proper use of masks, LVN 1 stated, No, we had not performed

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 -** Some	(continued... from page 1) audits before, but we will do now. LVN 1 stated it was important that staff are aware in the proper application of PPEs because if it was done incorrectly, it would increase the risk of transmission and spread of COVID-19. A review of minutes of post virtual tours by CDPH, and PHN on 7/29/20 indicated a recommendation was made to review proper handling of PPEs gown during doffing, and to post signs to keep doors closed in quarantine unit. A review of the facility's job description titled, Infection Preventionist Job Responsibilities, indicated the primary role of this position is to investigate, control and prevent infections in the long-term care environment in accordance with current federal, state, and local standards, guidelines and regulations that govern such programs. The job description indicated the function of the Infection Preventionist was to monitor infection control practices and procedures during rounds to ensure compliance with hand hygiene and barrier precautions in the facility. The job description indicated the IP is to provide education regarding standard and transmission-based precautions and good handwashing to residents and staff. The job description indicated the IP was to assist in coordinating education and training related to infection control issues based on facility specific problems or concerns. A review of the facility's undated policy titled, Staff Development In-Service Training-General Policies, indicated all personnel must attend and participate in regularly scheduled in-service training programs. The policy indicated primary objectives of the facility's in-service training program, one was to plan and organize a system of training that begins with an orientation program and continues throughout employment through scheduled in-service training programs and two, to teach each employee the specific policies and procedures of our facility.