STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056466	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SIERRA VIEW CARE CENTER	**14318 OHIO STREET BALDWIN PARK, CA 91706**

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** Based on observation, interview, and record review, the facility failed to follow infection control and prevention guidelines by failing to ensure the facility staff don the required personal protective equipment (PPE) prior to entering the residents room in the yellow zone (area designated for patients under investigation for Coronavirus Disease 2019 (Covid 19). The yellow zone is designated by the facility for patients with increased body temperature, cough and for those residents waiting for Covid-19 test results and/or have been exposed to Covid19). This deficient practice placed the residents at risk for infection and cross contamination. Findings: On 6/26/20 at 1:00 p.m. an unannounced visit was made to the facility regarding an increased in Covid-19 cases and four resident deaths. On 6/26/20 at 2:15 p.m., during an observation with the Director of Nurses (DON) and the facility's Infection Preventionist (IP), the facility staff were observed wearing white laboratory (lab) coats. During a concurrent interview, the DON stated the facility provided two white lab coats to each staff member as part of their uniform. DON stated staff is responsible to remove the white coat at the end of their shift and put it in a plastic bag prior to leaving the facility. DON stated it is the staff's responsibility to wash the lab coats at home every day and bring the cleaned coats every day to work. On 6/26/20 at 2:46 p.m., during an observation, Certified Nursing Assistant 1 (CNA 1) walked out of room [ROOM NUMBER]. room [ROOM NUMBER] is located in the yellow zone. CNA 1 was wearing a mask, a white lab coat, no gloves on, and no eye protection. During a concurrent interview, CNA 1 stated he donned PPE prior to entering the room and doffed the PPE before exiting the room. CNA 1 was holding a tied plastic bag with clothes inside. CNA 1 was observed touching the plastic bag with ungloved hands. CNA 1 stated the clothes inside the plastic bag were dirty clothes from a resident in room [ROOM NUMBER]. On 6/26/20 at 2:51 p.m., during an observation, a nursing staff member (unidentified) entered room [ROOM NUMBER]. room [ROOM NUMBER] is located in the yellow zone. The staff member was wearing a mask, a white lab coat, was not wearing yellow gown and had no eye protection. The nursing staff member was observed assisting the resident in bed B and talking to the resident in bed A. On 6/26/20 at 2:54 p.m., during an observation, Central Supply Staff 1 (CSS 1) responded to a call light in room [ROOM NUMBER]. room [ROOM NUMBER] is located in the yellow zone. The staff member entered the room without donning isolation gown, gloves, or eye protection. CCS 1 opened the resident's bathroom door, observed talking with the resident and informed the resident that he would call his nurse. CSS1 came out of the room, performed hand hygiene, and called the nurse. During a concurrent interview, CSS 1 said he answered the call light in room [ROOM NUMBER]. CSS 1 stated staff have to don a reusable/yellow gown, use eye protection, and wear gloves prior to entering a resident's room but he failed to do so. On 6/26/20 at 3:00 p.m., during an observation, Restorative Nursing Assistant 1 (RNA 1) was wearing a mask and a white lab coat while inside room [ROOM NUMBER]. room [ROOM NUMBER] is located in the yellow zone. RNA1 was not wearing yellow gown, gloves and eye protection. RNA1 talked to the resident in the room and then left. During a concurrent interview, RNA 1 said she answered the resident's call light because the resident needed assistance reaching the TV remote and she handed it to the resident. RNA 1 stated she was instructed by the IP that she has to don a yellow gown (reusable) gown, put on gloves and wear eye protection prior to entering residents' rooms in the yellow zone. RNA1 confirmed she failed to follow the facility's practice and was apologetic that she did not don appropriate PPE prior to entering the room. RNA 1 stated, to protect herself and the residents from being infected with Covid-19, she has to wear the right protective equipment. On 6/26/20 at 3:14 p.m., during an observation, Licensed Vocational Nurse 1 (LVN 1) checked the residents in room [ROOM NUMBER]. room [ROOM NUMBER] is located in the yellow zone. LVN1 had her gloves on but did not wear isolation gown. LVN1 was wearing a white coat and mask on. During an interview, LVN 1 said that she was doing her quick rounds at the start of her shift and said she will only wear the isolation gown when she does patient care. A review of the facility's undated policy and procedure titled, Infection Control Manual, [MEDICAL CONDITION] (Covid 19) indicated if Covid-19 transmission occurs in the facility, healthcare personnel should wear full PPE for the care of all residents irrespective of covid-19 [DIAGNOSES REDACTED]. Personal protective equipment (PPE) includes gloves, isolation gowns and facemasks.

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