STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056124	A. BUILDING _____ B. WING _____	07/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TARZANA HEALTH AND REHABILITATION CENTER	5650 RESEDA BLVD TARZANA, CA 91356

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 observe infection control measures by: a. Failing to ensure the direct cart staff don gloves when bringing a water pitcher into Resident 1's room and while assisting the resident to drink by holding the cup and the straw with bare hands. This deficient practice had the potential to result in transmission of bacteria that can lead to infection for one out of one resident (Resident 1). b. Failing to ensure Infection Control Policy and Procedure included a system of providing education to the healthcare staff regarding residents who have [DIAGNOSES REDACTED]. This deficient practice increased the potential for the development and/or spread of infections among residents and staff. c. Failing to ensure the kitchen staff were using a sanitizer testing strip bottle that was not expired. This deficient practice had the potential to provide an inaccurate measure of the sanitizing solution used in the facility kitchen and may not be effectively sanitizing any equipment in the kitchen. Findings: a. A review of Resident 1's Admission Record indicated an original admission to the facility dated [DATE] with a readmission on [DATE]. Resident 1's [DIAGNOSES REDACTED]. A review of Resident 1's Minimum Data Set (MDS- a standardized assessment and screening tool) dated [DATE], indicated the resident was unable to make decisions and needed extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. On [DATE] at 9:04 AM, while conducting a facility observation tour accompanied by Registered Nurse Manager (RNM), Certified Nurse 1 (CNA 1) was entering Resident 1's room bringing a pitcher of water without donning Personal Protective Equipment (PPE) except for a facemask. CNA 1 proceeded to pour water into a cup and placed a straw and assisted Resident 1, by holding the cup and the straw, with bare hands. Upon exiting the room, CNA 1 performed hand hygiene using a hand sanitizer from a wall dispenser. During an interview after CNA 1 left the room, CNA 1 acknowledged not wearing gloves. CNA 1 stated he forgot to wear gloved. RNM stated staff should observed infection protocol and use personal protective equipment as indicated in the posted PPE requirement prior to entering Resident 1's room. A review of the Acute Communicable Disease Control Manual (B-73) REVISION-[DATE], titled CORONAVIRUS DISEASE 2019 (COVID-19) Skilled Nursing Facilities, indicated the following, but not limited to: Infection control considerations in Cohorting: a. PPE: i. N95 respirators and masks may be worn throughout the day between all patients unless visibly soiled if PPE supplies are limited. ii. Gloves should be donned for each new resident in accordance with CDC standard precautions. Hand hygiene must be performed before and after glove use. iii. Gowns should be changed between each resident if PPE supplies permit. If gowns are limited, HCP may wear the same gown while caring for residents in the RED COVID area as long as the resident does not have another indication for contact precautions (i.e., [DIAGNOSES REDACTED]icile, CRE, etc.). Gowns should be changed when soiled in all cohorts and should be changed between residents within YELLOW quarantine areas. Disinfectant wipes can be used to disinfect non-porous plastic gowns between residents if consistent with the gown manufacturer instructions for use. Do not spray disinfectant on gowns or PPE as this may [MEDICAL CONDITION] particles on the gown. In the setting of PPE shortage, follow CDC PPE optimization strategy. b. A review of Resident 2's Admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. It's caused by [MEDICAL CONDITION] called coronavirus), and end stage [MEDICAL CONDITION] (longstanding disease of the kidneys leading to [MEDICAL CONDITION]). A review of Resident 2's MDS dated [DATE], indicated the resident was unable to make decisions and needed extensive assistance with bed mobility, transfer, dressing, toilet use and personal hygiene. A review of the physician's orders [REDACTED]. A review of Resident 2's [MEDICAL TREATMENT] Communication Record dated [DATE], indicated the [MEDICAL TREATMENT] was scheduled for 4:45 AM. The record included information entered by the [MEDICAL TREATMENT] Center that stated that [MEDICAL TREATMENT] was completed without incident and signed by the [MEDICAL TREATMENT] nurse. On [DATE] at 9:15 AM, during a tour of the facility, accompanied by RNM and while walking in the hallway of Station 1, Resident 2 was observed being wheeled in a gurney by two medical transport personnel and stopped at Nursing Station 1. One of the medical transport personnel was heard asking, Where is the COVID Uni? and was then given direction by a nursing staff. The COVID-19 Unit was in the far end passing thru the lobby and the rehabilitation room as explained by the RNM. According to the RNM, the medical transport personnel should have entered thru the back door designated for COVID-19 residents when transported to the [MEDICAL TREATMENT] centers as an infection control protocol for those with active COVID-19 infection as they are highly infectious. On [DATE] at 12:41 PM, during an interview with the MDS Nurse (MDSN) in the presence of the RNM, MDSN stated that she was covering the main lobby entrance and was told by the medical transport personnel that they are bringing in a resident from [MEDICAL TREATMENT] and was not informed by the transport personnel that this particular resident was COVID-19 positive. According to MDSN, it was her first day back at work from a leave of absence and was just covering for the regular staff assigned in the front lobby to screen employees and staff upon entering the facility. At 1 PM, during a follow up interview, RNM and review of a tool kit, titled Managing COVID-19 in your Center, RNM was unable to find a provision regarding transporting resident with COVID-19 to [MEDICAL TREATMENT] centers and providing for a separate entrance. RNM stated their in-service training did not include COVID-19 residents should use a separate entrance and exit when going for [MEDICAL TREATMENT]. A review of the facilities Infection Prevention Manual for Long Term Care- Infection Prevention Program Overview with revision date of ,[DATE], indicated in Section V Updating the Infection Prevention Plan, that infection Prevention policies, procedures, activities and practices will be reviewed, at a minimum, annually and updated, as indicated, as part of the Facility Assessment, for changes in services, changes in population served, or other changes as appropriate. This Infection Prevention Manual does not include management of COVID-19 patient as it predates the emergence of Coronavirus ([DIAGNOSES REDACTED]-CoV-2) that causes COVID-19. c. During a concurrent observation and interview with the Kitchen Supervisor (KS) on [DATE] at 9:17 AM, a test run was conducted of the kitchen's washing machine. KS stated they use a low temperature washing machine with chlorine solution for sanitizing. The observed water temperature was at 120 degrees Fahrenheit. KS obtained the sanitizer testing strip bottle being used to test the concentration of the sanitizing solution. The testing strip bottle had an expiration date of [DATE]. KS obtained another testing strip bottle and the second bottle had an expiration date of [DATE]. KS obtained a third testing strip bottle which had an expiration bottle of [DATE]. KS did a test run with the new testing strip bottle and test came out with 100 ppm (parts per million; normal range for chlorine solution is ,[DATE] ppm). KS stated they should not be using a test strip bottle that is expired. KS stated that a test strip bottle that is expired may not accurately measure the solution's concentration and may not be effectively sanitizing anything placed in the dishwasher. A review of the facility's Dish Machine Log for the month of [DATE], indicated that testing was completed and solution was within normal range. A review of the facility's policy and procedures titled, Warewashing, revised on ,[DATE], indicated, Temperature and/or sanitizer concentration logs will be completed, as appropriate.

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.