STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555076	A. BUILDING _____ B. WING _____	**05/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVOCADO POST ACUTE	**510 E. WASHINGTON AVENUE EL CAJON, CA 92020**

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 -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility failed to follow infection control precautions when two staff members entered one of 11 residents rooms, identified as contact/droplet (infections that can spread by touching, coughing, sneezing or speaking) precautions for Persons Under Investigation (PUI), for possible COVID-19 exposure, without wearing the proper Personal Protective Equipment (PPE). This failure had the potential for cross contamination of infection to other residents and staff. Findings: During an unannounced visit, an observation was conducted on 5/13/20 at 3:52 P.M., in the southeast hallway of Station One. Certified nursing assistant (CNA 6) was observed to have entered the doorway of a PUI resident room. Outside of the resident room was a clear plastic cart, which contained gloves and yellow PPE gowns. Signage on the outside plastic door covering identified the room as a contact/droplet precaution room, with Caution: face mask, eye shield, gown and gloves required. CNA 6 entered the resident room through a vertical zipper in the middle of a clear-plastic door frame covering, without donning (to put on) a PPE gown. Inside the resident room, to the immediate right of the entrance, a yellow PPE gown was hanging on the wall, which had not be donned by CNA 6. CNA 6 was observed through the room's plastic door covering, moving around the room in maroon scrubs (a two-piece cotton cloth medical attire). On 5/13/20 at 3:52 P.M., an observation and interview was conducted with Licensed Nurse (LN 3). LN 3 exited the PUI room, while CNA 6 remained in the room. LN 3 exited through the unzipped plastic door covering without wearing any PPE before exiting. LN 3 was wearing a shirt, denim jacket, denim pants and was carrying a medication tray with a glucometer (a portable device that measures sugar levels in the blood). LN 3 stated the residents in the PUI room were on isolation for possible exposure from other residents who were COVID-19 positive. LN 3 stated PPE was no longer required, since their isolation period had been over 14 days. LN 3 stated the charge nurse told her yesterday that the isolation precautions were over because the residents had not shown any signs or symptoms of COVID-19. LN 3 stated PPE gowns were no longer required and someone should have removed the caution signs. LN 3 was unaware of the COVID-19 test results for the three residents inside the PUI room. On 5/13/20 at 3:59 P.M., an observation and interview was conducted with CNA 6. CNA 6 exited the PUI room without wearing a PPE gown. CNA 6 stated she was in the room to get the residents' vital signs (temperature, blood pressure, and pulse rate). CNA 6 stated she should have put on a protective gown and she did not. CNA 6 stated by not donning a PPE gown there was a risk of transmission of infection to other residents and staff. On 5/13/20 at 4:01 P.M., an interview was conducted with the infection control nurse (ICN). The ICN stated the residents in the PUI room were on isolation due to possible exposure to the COVID-19 virus. The ICN stated one resident's test came back negative, but the two remaining residents' test were still pending. The ICN stated the physician did not want the residents removed from isolation until the test results were back and confirmed to be negative. The ICN stated if the room was sealed and identified as an isolation room, she expected all staff to use the required PPE when entering and exiting the room. The ICN stated by not using the required PPE, the staff members were placing the entire unit at risk of the spread of infection. On 5/13/20 at 4:18 P.M., an interview was conducted with the Administrator (ADM). The ADM stated her expectation was all staff should use PPE when they entered a residents room identified as an isolation room. The ADM stated when staff were not wearing the PPE gowns, it placed others in the facility at risk of infection. According to the facility's policy, titled Emergency Management Plan: COVID-19, undated, .Provide the rights supplies to ensure easy and correct use of PPE for residents infected with COVID-19: Post signs on the door or wall outside the resident rooms that clearly describe the type of precautions needed and required PPE. Make PPE .available immediately outside of the resident room .

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