STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. BUILDING _____ B. WING _____	**08/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MADERA REHABILITATION & NURSING CENTER	**517 SOUTH A STREET MADERA, CA 93638**

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** - Potential for minimal 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 interview and record review the facility failed to provide staff with guidance on how to mitigate the spread of COVID-19 associated with Aerosol Generating Procedures (AGP). Failure to provide staff with guidance on how to mitigate the spread of COVID -19 with nebulizer treatments, suctioning and or the performance of cardiopulmonary resuscitation could potentially contribute to the spread of [MEDICAL CONDITION]. Findings include: Multiple observations, interviews and record reviews occurred throughout the survey. On [DATE], reviewed the nebulizer policy and procedure. The policy had no specificity regarding actions for staff to take to mitigate spread of illnesses with AGPs. During an interview with the Director of Nurses (DON) on [DATE], there were only two residents with active nebulizer treatment orders and they were receiving the treatments on an as needed basis. Observed no ventilators, continuous positive airway pressure devices or sleep apnea machines during the survey. During further interview with the DON, she acknowledged some residents within the facility had full cardiopulmonary resuscitation (CPR) status. That is, if some residents required CPR then the facility would provide CRP. As of [DATE], the facility did NOT provide evidence of guidance to staff on how to mitigate the potential spread of COVID-19 with AGPs.

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.