STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055126	A. BUILDING _____ B. WING _____	**07/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHINO VALLEY HEALTH CARE CENTE	**2351 S TOWNE AVENUE POMONA, CA 91766**

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 prevent the development and transmission of COVID-19 communicable diseases and infections by not following standard infection control practices. The facility staff was exiting from the yellow zone (dirty zone) and then entering into the green zone (clean zone). The facility staff also failed to use personal protective equipment (PPE) appropriately. This deficient practice resulted in contamination and increase the spread or exposure of serious respiratory illnesses to residents and staff of the facility. Findings: An unannounced visit to the facility was conducted on 7/1/20 at 12:45 pm for COVID-19 Infection Control Practices. 1. During an initial tour on 7/1/20 at 1:25 pm, and in the presence of the Director of Staff Development (DSD), the green zone (for negative COVID-19 residents) located in the North station of the facility was observed with a clear plastic barrier, dividing the green zone and yellow zone (for residents being monitored for symptoms). The plastic barrier was not secured to the floor or bottom lateral sides, allowing air to pass from the yellow zone to the green zone. The plastic barrier was free flowing and lifting up by the breeze. During this same observation, a staff was observed exiting from the yellow zone by unzipping the plastic barrier, and entering into the green zone. The DSD was observed redirecting the staff. The DSD stated that all zones within each station had separated entrance and exit and that there was no reason for the staff to be exiting into another zone, especially into the green zone. The DSD stated that by the staff exiting into the green zone, there would be a potential for cross contamination, due to dirty to clean. During an observation of the yellow zone in the North station, on 7/1/20 at 1:43 pm, one resident's door was observed open. During this same observation, a staff was observed pushing two wheelchairs from the yellow zone into the green zone. During an observation of the yellow zone of the South station, on 7/1/20 at 1:50 pm, the door for three residents was observed open. At this time, the DSD reminded staff to close the door. 2. During an interview on 7/1/20 at 2:16 pm, Registered Nurse (RN) 1 stated that when on break, the reusable gown is put into a bag and disinfected. RN stated that upon returning from break, the same gown is being reused, and not being replaced with another gown. During an observation of the red zone in the South station 7/1/20 at 2:18 pm, RN 1 was observed going out of the red zone, attempting to locate a bin for disposing non-reusable PPE. RN 1 was wearing the same reusable gown outside of the red zone area. During an interview on 7/1/20 at 2:40 pm, and in the presence of the Director of Nurses and Administrator, the DSD stated that reusable gowns are discarded in a bin for laundering and not reused. The DSD stated that staff are to dispose the reusable gown in the bin and obtain a new reusable gown upon returning from break or providing direct patient care. The DSD stated that disinfecting reusable gowns was not done. During this same interview, the DSD stated staff were not allowed in other zones, and that crossing each zones was not done. During an interview on 7/1/20 at 2:50 pm, the DON stated that going to the yellow zone into the green zone should not be done, due to cross contamination from dirty to clean. A review of the facility's Mitigation Plan for COVID-19 dated 5/26/20 indicated the facility will distinct the separation of the unit either by closing doors (fire door) or putting up a plastic drape or barricade. The facility will designate a clean and dirty area within the unit. Clean area is where staff do the donning of PPE. Dirty area is where staff the doffing of PPE and collect reusable PPE for disinfection
F 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** Based on observation and interview, the facility failed to provide a safe and sanitary environment for the staff and the public, regarding liquid waste discharging onto the ground and no hot water at a designated handwashing sink. This deficient practice of liquid waste discharge and no hot water threaten the safety and health of the staff and the public. Findings: On July 1, 2020, at 12:45 p.m., a complaint investigation was initiated and the director of nursing (DON) was informed of the visit. Between 1:10 p.m. and 2:55 p.m., the survey team and the Infection Control Preventionist (IP) conducted a general observation of the facility. The survey team and the IP wore Personal Protective Equipment (PPE) during this observation (PPEs are isolation gowns, footwear protection, gloves, face masks and face shields or safety glasses to protect from being exposed to COVID-19 (a contagious disease that causes severe respiratory distress, possibly even death, and is easily spread from person to person)). At 2:25 p.m., upon entering the Red Zone (the area where the COVID positive residents were located), it was observed that there was a designated free standing handwashing sink (20 inches wide, 14 inches deep and 36 inches high) with a soap dispenser and a paper towel dispenser, next to the entrance door (outside of the facility). At 2:50 p.m., after removing the PPEs, the IP and the survey team washed their hands at the handwashing sink. It was noticed that there was no hot water at this handwashing sink. A closer observation revealed that the water came from a garden hose attached to this sink and a 2-inch round plastic flexible tube was discharging the liquid waste, or greywater, onto the ground (Greywater is the wastewater from sinks, bathtubs, and showers, which may contain dirt, soap and biological matter, such as skin flakes, blood, urine, fecal bacteria and other bodily fluids.) At 3:05 p.m., an interview was conducted with a maintenance staff regarding this handwashing sink. The maintenance staff stated that this handwashing sink was installed a couple of weeks ago. During this interview, it was mentioned that there was no hot water at the handwashing sink and the greywater was discharging onto the ground. The maintenance staff knew that the handwashing sink should have hot water, but the water could not be heated from the garden hose. And the maintenance staff thought it was ok to allow the greywater to be discharged on to the ground and go into the storm drain at the street. (According to the California Code of Regulations, Title 22, Licensing and Certification of Health Facilities, Section (b), all plumbing facilities shall be maintained in compliance with the California Administrative Code, Basic Plumbing Requirements, Title 24, Part 5, Section 1011(e), which states temperature control valves shall be provided to automatically regulate the temperature of hot water delivered to plumbing fixtures to a minimum of 105 F to a maximum of 120 F. This requirement also states that all liquid waste shall be deposited into an approved sewer system.) At 3:30 p.m., an interview was conducted with the administrator regarding the handwashing sink outside of the Red Zone. The administrator was informed that the facility did not have hot water to this handwashing sink and the greywater was not discharging into an approved sewer system. Thus, the facility was not providing a safe and sanitary environment for the staff and the public, and was in violation of a Federal regulation.

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