STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555814	A. BUILDING _____ B. WING _____	**09/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOLDEN LEGACY CARE CENTER	**12260 FOOTHILL BLVD SYLMAR, CA 91342**

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 implement infection control measures to prevent the spread and control Coronavirus Disease 2019 (COVID-19 - a [MEDICAL CONDITION] contagious infection affecting the respiratory systems and can be severe and cause death. COVID-19 transmit from person to person and from contaminated surfaces) by: 1. Failing to ensure health care personnel (HCP) performed hand hygiene, Failing to wear the appropriate Personal Protective Equipment (PPE-equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) per designated zones, Failing to proper donning (putting on) and taking off PPE, Failing to observe six feet physical distancing. 2. Failing to ensure transmission of infectious agents were minimized by failing to reduce the number of bed transfers until after COVID-19 test results came back. These deficient practices have the potential to result in the increase of confirmed COVID-19 residents in the facility. Findings: 1. During an observation on 9/11/2020 at 2:26 p.m., two HCP were no wearing face shield in the sub-acute unit hallway and three HCP in the Sub-Acute Unit Nursing Station not observing six feet physical distancing. On 9/11/2020 at 2:27 p.m., during an interview, Infection Preventionist Nurse (IPN) stated HCP re-uses the face shield and store them at the nursing station in a brown bag. HCP must wear N-95 mask (or N95 respirator is a particulate-filtering facepiece respirator that meets the U.S. National Institute for Occupational Safety and Health N95 classification of air filtration, meaning that it always filters at least 95% of airborne particles) and face shield. On 9/11/2020 at 2:28 p.m., one HCP entered from the Yellow Zone (area designated for residents newly admitted or waiting for test results or residents on [MEDICAL TREATMENT] outside the facility three times a week) went inside the Yellow Zone Employee Lounge and then, went to sub-acute Green Zone (residents free of COVID-19). On 9/11/2020 at 2:30 p.m., during an interview, IPN stated reusable gowns are discarded in a black bin and every resident's room has one. There was a black bin outside of resident's room in the Yellow Zone hallway. On 9/11/2020 at 2:34 p.m., Licensed Vocational Nurse 1 (LVN 1) was observed answering the call light of room [ROOM NUMBER]. LVN 1 put on the gown, gloves, and did not tie the lower string of the gown and entered room. Inside the room, LVN 1 removed the gloves, went inside the resident's restroom, washed her hands, the removed gown, applied hand sanitizer, then disposed reusable gown in a black bin located by the entrance door. LVN 1 did not wash her hands after disposing the contaminated gown. LVN 1 proceeded to answer the call light at another resident's room. ICN, present at the time of the observation, stated reusable gown discard bin should be inside resident's room and staff should be discarded before exiting the resident's room. ICN stated LVN 1 should have performed hand hygiene after disposing gown and should have tied the neck and back strap of the gown. On 9/11/2020, at 2:39 p.m., during an observation with IPN, Certified Nursing Assistant 1 (CNA 1) exited a resident's room holding a soiled linen in clear plastic bag and disposed it on the soiled linen bin. CNA 1 exited the closed fire door separating Station 1 from Station 3 and did not do hand hygiene. CNA 1 entered from the Yellow Zone area and straight into the Yellow Zone Employee Lounge, then went to the Sub-Acute Green Zone area. At the time of the observation, IPN stated CNA 1 should have performed hand hygiene after handling soiled linen and before exiting the unit. ICN stated staff working in the Green Zone should enter from the designated Green Zone to the Sub-Acute Unit and not from the Yellow Zone. On 9/11/2020, at 2:50 p.m., during an observation with IPN, LVN 2 was in the Red Zone (residents positive for COVID-19) Nursing Station, tied her hair back with tie and put on a N95 mask and proceeded to the medication cart without washing her hands. LVN 2 was not wearing face shield. ICN stated staff are expected to wear face shield in all the zones. 2. On 9/11/2020 at 3:12 p.m., during an interview, ICN stated four positive residents (Residents 1, 2, 3, 4) were all in Nursing Station 2 Yellow Zone on the same hallway with the most recent exposure on 9/1/2020. During an interview on 9/11/2020 at 3:12 p.m., IPN stated four positive residents (Residents 1, 2, 3, 4) were all in Station 2 Yellow Zone after being moved from Station 1 Yellow Zone on 9/9/2020. All four residents were tested on [DATE] and on 9/10/2020 the results came back positive for COVID-19. Station 1 Yellow Zone was going to become a Green Zone on 9/10/2020. IPN explained the movement of the four residents without waiting for the result was an administrative decision. At 3:38 p.m., the Assistant Administrator confirmed it was an administrative decision to move the residents because they were expecting a new admission. During an interview on 9/22/2020 at 4:45 p.m., IPN stated a mass testing of residents was done on 9/14/2020 and Residents 5, 6, 7, and 8, form Station 2 Yellow Zone who were previously negative, were positive for COVID-19. A review of the facility's policy and procedure titled COVID-19 Care released date 7/2020 indicated that it is the policy of this facility to ensure that clinical practice guidelines for treatment and management of COVID-19 are updated according to new and emerging evidenced based, peer review practice. Procedure: 7. If the facility has established unit and area for COVID-19, move the patients to the isolation area and follow: d. Isolation Zoning Algorithm i. Green zones are patients with no exposure to COVID-19 or those with negative results without known exposure within the last 14 days. ii. Yellow zones are patients exposed to COVID-19 or those with negative results but with known exposure within the last 14 days. iii. Red zones are patients that are positive COVID-19 or those with positive results. A review of the facility's policy and procedure titled Hand Hygiene released date 8/2017 indicated that all staff having direct resident contact will use appropriate hand hygiene to reduce transmission of pathogenic microorganisms to residents and personnel in the facility. A review of the facility's training titled Isolation Precautions dated 9/11/2020 indicated it is the facility's policy to provide a system of precautionary measures to reduce the potential transmission of infection.

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.