STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555521	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RANCHO MESA CARE CENTER	9333 LA MESA DRIVE ALTA LOMA, CA 91701

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 -** Many	**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 prevention and control practices to prevent the development and transmission of COVID-19 in a universe of six residents when: 1. Facility Staff did not follow transmission based precautions (precautions used to help stop the spread of germs from one person to another) to prevent the spread of infection for Residents 1 and 2 when Housekeeping Staff (HS 1) and a Certified Nursing Assistant/Restorative Nursing Assistant (CNA/RNA 1) failed to wear goggles or a face shield when entering a droplet precaution isolation room (droplet isolation precautions are used for infections, diseases, or germs that are spread to others by speaking, sneezing, or coughing. Healthcare workers should wear a gown, gloves, and goggles or face shield while in the patient's room). 2. Housekeeping staff cleaned floors on the PUI Unit (Person Under Investigation-designated to be used and occupied by those residents who were new admissions to the facility and their COVID 19 status was unknown) with a disinfectant that was not an EPA (Environmental Protection Agency)-registered disinfectant qualified for use against [DIAGNOSES REDACTED]-COV-2 (COVID 19). This failure had the potential to cause an infection to spread to other residents of the facility. Findings: 1. A review of Resident 1's face sheet (a document that gives a summary of resident's information), undated, indicated Resident 1 was admitted to the facility on [DATE]. Resident 1 occupied a room on the PUI Unit (Person Under Investigation-designated to be used and occupied by those residents who were new admissions to the facility and their COVID 19 status was unknown) of the facility. Resident 1 had been placed on droplet precaution isolation due to being a new admission to the facility. A review of Resident 2's face sheet (a document that gives a summary of resident's information), undated, indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 occupied a room on the PUI Unit (Person Under Investigation-designated to be used and occupied by those residents who were new admissions to the facility and their COVID 19 status was unknown) of the facility. Resident 2 had been placed on droplet precaution isolation due to being a new admission to the facility. During an observation of a room on the PUI unit on July 24, 2020 at 9:30 AM, a name plate mounted on the wall, next to the room's door, indicated the names of Resident 1 and 2. Signs posted on the wall, next to the room's door, indicated PUI (Person under investigation) Unit Notice: Anyone entering this area must wear the following PPE (Personal Protective Equipment): Gown, Mask, Face Shield or Goggles, Gloves, Covid 19 Isolation room PUI Unit Contact/droplet isolation-Before you enter, you must: perform hand hygiene, wear isolation gown, face shield, hair cover, gloves. (Room number) start date: 7/14/20 (July 14, 2020) end date: 7/28/20 (July 28, 2020). An isolation cart was positioned outside the room. On top of the cart was a box of gloves and a container of disinfecting wipes. The top drawer contained 75 percent alcohol wipes and a stethoscope. The second drawer contained disposable and cloth gowns. The third drawer contained cloth gowns. The cart did not contain goggles or face shields. Positioned next to the room's door was a dirty linen bin. Hand sanitizer was on wall across from the cart. During an observation and interview with Housekeeping Staff (HS 1) on July 24, 2020 at 9:40 AM, HS 1 was observed inside of the room mopping the floor, cleaning the room and emptying the trash cans. HS 1 was wearing eyeglasses, mask, gown and gloves. HS 1 did not have goggles or a face shield on. HS 1 stated she did not have a face shield or goggles on because she forgot. HS 1 stated she did not know where the goggles or face shields were kept. During an observation and interview with a Certified Nursing Assistant/Restorative Nursing Assistant (CNA/RNA 1) on July 24, 2020 at 9:45 AM, CNA/RNA 1 was observed entering Resident 1 and 2's room. CNA/RNA 1 donned (to put on) a gown and gloves. CNA/RNA 1 already had on a face mask. CNA/RNA 1 entered the room without wearing goggles or a face shield. CNA/RNA 1 provided cares for Resident 1. CNA/RNA 1 stated she did not wear a face shield and should have. CNA/RNA 1 stated she did not know where to get goggles or a face shield. CNA/RNA 1 stated she had not discarded her face mask after leaving the isolation room. CNA/RNA 1 stated, I wear the same mask all day. During an interview with an Infection Preventionist (IP) on July 24, 2020 at 10 AM, the IP stated HS 1 and CNA/RNA 1 had entered Resident 1 and 2's room without goggles or a face shield. The IP stated goggles or a face shield were required to don before entering the room. The IP stated goggles, face shields and face masks were not available on the isolation cart outside of Resident 1 and 2's room. A review of the facility's policy and procedure titled, Isolation-Initiating Transmission-Based Precautions, dated January 2012, indicated the following: Policy Statement: Transmission-Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. Transmission-Based Precautions may include .Droplet Precautions. Policy Interpretation and Implementation: .When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee) shall: Ensure that protective equipment (i.e., gloves, gowns, masks, etc.,) is maintained near the resident's room so that everyone entering the room can access what they need. A review of the facility's policy and procedure titled Personal Protective Equipment - Using Protective Eyewear, dated September 2010, indicated the following: Objectives: .To protect the employee's eyes, nose, and mouth from potentially infectious materials. Miscellaneous: .eye protection devices, such as goggles or glasses with solid side shields or chin-length face shields, shall be worn together whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be expected. Personal eyeglasses should not be considered as adequate protective eyewear. Protective eyewear must have adequate side and top coverage and must fit the employee properly. 2. During an observation and interview with a Housekeeping Staff (HS 1) on July 24, 2020 at 2:19 PM, HS 1 stated the Housekeeping Director (HD) was not in the facility at this time but she (HS 1) could explain and demonstrate how the PUI unit rooms were disinfected. HS 1 stated she had performed terminal cleaning (a thorough, deep-cleaning of a patient room between occupants. Its purpose was to rid the room of infectious agents and provide the new occupant a sanitary space) of rooms on the PUI unit. HS 1 opened a door to a supply closet in the facility. Inside the closet were cleaning tools (mops, buckets, etc.) and mounted to the wall were two containers with hoses coming out the bottom of each container. HS 1 stated container one held (disinfectant A) and this was the disinfectant she used to clean the facility's high touch surfaces. HS 1 stated container two held (disinfectant B) and this was the disinfectant she used to clean the facility's floors, including the floors of the rooms on the PUI unit. Container one, for disinfectant A, indicated an EPA number and container two, for disinfectant B, did not indicate an EPA number. HS 1 stated she was unaware of EPA numbers. HS 1 stated the disinfectant in containers one and two were already diluted to the manufacturer's instructions. HS 1 stated she would fill her buckets on her cleaning cart with the hoses from container one and container two. HS 1 stated she would then take her cleaning cart to the room that required cleaning. HS 1 stated she cleaned the floors of the rooms on the PUI unit with disinfectant B and the floors needed to stay wet for 10 minutes in order to kill [MEDICAL CONDITION]. During an interview and record review with the Director of Nursing (DON) on July 24, 2020 at 1:44 PM, The DON stated disinfectant B did not have an EPA number and was not qualified for use against [DIAGNOSES REDACTED]-COV-2 (COVID 19). The DON stated HS 1 should have used disinfectant A to clean the facility's floors, not disinfectant B. The facility did not provide a policy and procedure indicating the procedure to disinfect the floors of rooms on the PUI unit.

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