STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056072	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PETALUMA POST-ACUTE REHABILITATION	**1115 B STREET PETALUMA, CA 94952**

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.** Based on observation, interview, and record review, the facility failed to implement a system to control transmission of infection within its facility, when it did not establish a process to audit staff compliance with: (1) Personal protective equipment (PPE, clinical equipment that acts as barriers to minimize staff and resident exposure to a variety of hazards) processes; and (2) Hand hygiene (cleaning hands to prevent the spread of germs) processes. These failures did not ensure a safe environment for care and did not facilitate control of COVID-19 transmission among residents and staff. Findings: (1) During an interview on 7/8/20, at 9:50 a.m., Director of Nursing (DON) stated the facility used Wing C as its COVID wing, and the facility had moved exposed residents suspected for COVID-19 to Wing C once the residents became symptomatic or tested positive. During an observation on 7/8/20, during a facility tour between 10:12 a.m. and 11:00 a.m., Unlicensed Staff A donned PPE prior to entering a resident's room on Wing C. Unlicensed Staff A did not perform hand hygiene before donning gloves. Unlicensed Staff A donned personal eyeglasses (which did not protect the side of Unlicensed Staff A's face/eye), instead of goggles or face shield. Unlicensed Staff A entered the room, then performed and completed her task. Upon completion, Unlicensed Staff A doffed her gloves and gown, exited through the room's doorway, and disposed of both items in a trash bin located in the hallway outside the resident's room. Unlicensed Staff A then re-entered the resident's room wearing only an N95 respirator for PPE; no gown or gloves. Unlicensed Staff A walked into the resident's bathroom and closed the door behind her. During an observation on 7/8/20, during a facility tour between 10:12 a.m. and 11:00 a.m., Unlicensed Staff C donned PPE in preparation for entering a resident's room on Wing C. Unlicensed Staff C donned gloves last in the PPE-donning sequence. During an observation on 7/8/20, during a facility tour between 10:12 a.m. and 11:00 a.m., Licensed Staff B donned PPE in preparation for entering a resident room on Wing C. Licensed Staff B donned gloves first in the PPE-donning sequence. During an interview on 7/8/20, at 11:30 a.m., in the presence of the DON, the DSD (Director of Staff Development) stated she was the facility's primary Infection Preventionist (IP). The DSD stated she was accountable for the responsibilities of both jobs, DSD and IP. The DON stated both she the Administrator provided support to the DSD for the facility's IP needs. The DSD stated the facility did not audit healthcare workers on the COVID-19 unit for compliance with appropriate PPE donning and doffing practices. The facility policy and procedure titled Infection Prevention and Control: Novel Coronavirus (COVID-19), dated 6/9/20, indicated the following requirement: Limit only essential personnel to enter the (COVID-19 resident's) room with appropriate (PPE) and respiratory protection. Also, the facility policy and procedure indicated (PPE) includes: . (e)ye protection that covers the front and sides of the face . The facility's competency validation form for Donning and Doffing PPE, dated 9/2016, indicated a sequenced list of steps required by staff when donning and doffing PPE. The form indicated staff must (d)on gloves last when applying PPE for resident care. The form indicated staff must (d)on (g)oggles or (f)ace (s)hield. A review of CDC guidance, titled Responding to Coronavirus (COVID-19) in Nursing Homes, dated 4/30/20, indicated a skilled nursing facility should Place signage at the entrance to the COVID-19 care unit that instructs HCP ((healthcare personnel)) they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html, accessed 7/9/20). A review of CDC guidance, titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated 7/9/20, indicated Personal eyeglasses and contact lenses are NOT considered adequate eye protection. (Emphasis provided)(https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html, accessed 7/14/20). (2) During an interview on 7/9/20, at 9:50 a.m., Director of Nursing (DON) stated the facility used Wing C as its COVID wing, and the facility had moved exposed residents suspected for COVID-19 to Wing C once the residents became symptomatic or positive. During an observation on 7/9/20, during a facility tour between 10:12 a.m. and 11:00 a.m., Unlicensed Staff A donned PPE prior to entering a resident's room on Wing C. Unlicensed Staff A did not perform hand hygiene before donning gloves. Unlicensed Staff A entered the room, then performed and completed her task. During an observation on 7/9/20, during a facility tour between 10:12 a.m. and 11:00 a.m., Unlicensed Staff C donned PPE in preparation for entering a resident's room on Wing C. Unlicensed Staff C donned gloves, but did not perform hand hygiene prior to donning. During a concurrent interview and record review on 7/9/20, at 11:30 a.m., in the presence of the DON, the DSD (Director of Staff Development) stated was the facility's primary Infection Preventionist (IP). The DSD stated she was responsible for training staff and verifying staff competency with hand hygiene. The DSD stated the facility had started auditing staff for compliance with hand hygiene processes. The DSD stated the facility observed staff and used the hand hygiene competency validation to guide the auditing process. On review of the facility's competency validation form for hand hygiene, the DSD stated the form did not indicate a process for auditing hand-hygiene compliance. The DSD stated the facility did not use an audit tool that identified opportunities for hand hygiene, or indicated whether staff performed hand hygiene at each opportunity. The facility policy and procedure titled Infection Prevention and Control: Novel Coronavirus (COVID-19), dated 6/9/20, indicated the facility will re-educate and reinforce strong hand hygiene practices. The facility's competency validation form for Hand Hygiene Competency Validation, dated 9/2016, indicated processes staff must follow to competently perform hand hygiene. The form indicated the process steps when performing hand hygiene with soap & water and hand hygiene with ABHR (alcohol-based hand rub), as well as three general observations. The form did not indicate when staff must perform hand hygiene (e.g., opportunities for hand hygiene), or describe a process for auditing staff compliance with hand hygiene at each opportunity. A review of CDC guidance, titled Hand Hygiene in Healthcare Settings, dated 1/31/20, indicated gloves are not a substitute for hand hygiene, and staff should perform hand hygiene prior to donning gloves, and immediately after removing gloves. (https://www.cdc.gov/handhygiene/providers/index.html, accessed 7/14/20).

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.