STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555286	A. BUILDING _____ B. WING _____	**09/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW ORANGE HILLS	**5017 E. CHAPMAN AVENUE ORANGE, CA 92869**

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 facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to ensure the washable gowns used as personal protective equipment (PPE) were designated only as single use for the residents on droplet precautions. Instead, the facility designated one washable gown to be reused by the same staff member throughout their shift for all residents on droplet precautions who were in the same room. There were no shortages of gowns at the facility. * The facility failed to ensure the washable gowns being reused were labeled to identify which staff member the gown belonged to. * The facility failed to ensure the staff knew how to properly remove the PPE. * The facility failed to ensure the washable gowns being reused as the PPE were kept off of the floor. * The facility failed to ensure the staff changed gloves and performed hand hygiene between providing care for two residents. These failures had the potential for cross-contamination and spread of infectious organisms in the facility. Findings: Review of the Centers for Disease Control and Prevention's (CDC) article titled Strategies for Optimizing the Supply of Isolation Gowns revised on 3/17/2020, showed surge capacity refers to the ability to manage a sudden increase in patient volume that would severely challenge or exceed the present patient capacity of a facility. Surge capacity is a useful framework to approach a decreased supply of isolation gowns during the COVID-19 response. Three general levels have been used to describe surge capacity and can be used to prioritize measures to conserve isolation gown supplies along the continuum of care: * Conventional capacity: Measures consisting of engineering, administrative, and personal protective equipment (PPE) controls that should already be implemented in general infection prevention and control plans in healthcare settings. * Contingency capacity: Measures that may be used temporarily during periods of expected isolation gown shortages. * Crisis capacity: Strategies that are not adequate with U.S. standards of care but may need to be considered during periods of known gown shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. According to the Centers for Disease Control and Prevention (CDC) hand hygiene is performed: - before and after having direct contact with a patient's intact skin (taking pulse or blood pressure, performing physical examinations, lighting the patient in bed); - after contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings; - after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient; - if hands will be moving from a contaminated-body site to a clean-body site during patient care; and - after glove removal. Review of the Orange County Health Care Agency's (OCHCA) Guidance on COVID-19 in SNFs (skilled nursing facilities) dated 8/30/2020, showed due to limited supplies of disposable gowns, the healthcare facilities are encouraged to purchase long sleeved, washable cloth gowns. Gowns should be single use, being washed or discarded after each use. In periods of severe shortage, the facility can assign one gown per healthcare worker per patient per shift. Single use of gowns is best. If gown supplies are insufficient, reuse of gowns may be considered with prior approval obtained from OCHCA. 1a. Review of the facility's undated Facility Map showed there were 10 resident rooms in the Yellow Zone. On 9/8/2020 at 1045 hours, an interview was conducted with the Administrator and DON. When asked about the facility's PPE inventory, the Administrator stated the facility did not have a shortage of PPE. The DON was asked about the required PPE for the Red and Yellow Zones. The DON stated any persons entering the rooms in the Red or Yellow Zones were required to wear the appropriate PPE, including N95 masks, goggles or face shields, gloves, and gowns. The Administrator stated for resident rooms in the Yellow Zone, each staff had one washable gown to reuse throughout their shift for all of the residents in the same room. On 9/8/2020 at 1110 hours, Room A in the Yellow Zone was observed being occupied by three residents. Two washable gowns were observed hanging on the door of the residents' room. CNA 1 who was in the room was observed removing her washable gown and hanging it on the door. CNA 1 stated the gown was reused throughout her shift. CNA 1 stated she used the same gown for every resident in the room. CNA 1 stated the facility instructed her to use the same gown for all of the residents in the same room. CNA 1 stated the staff were supposed to label the gowns with their name. b. On 9/8/2020 at 1128 hours, Room B in the Yellow Zone was observed being occupied by three residents. Three washable gowns were observed hanging on the door of the residents' room. LVN 1 who was in the room was observed removing her washable gown and hanging it on the door. On 9/8/2020 at 1133 hours, LVN 1 was observed reentering Room B and donning the same washable gown to administer the medication to the resident in the room. LVN 1 was then observed removing her gown and hanging it on the door. LVN 1 stated she was instructed to reuse the washable gowns and that she could use the same gown for all of the residents in the same room. c. On 9/8/2020 at 1144 hours, Room C in the Yellow Zone was observed being occupied by two residents. Four washable gowns were observed hanging on the door of the residents' room. Two of the four washable gowns were observed hanging on the same hook (one gown was hung over the other). On 9/8/2020 at 1152 hours, an interview was conducted with LVN 2. LVN 2 stated the gowns were reused by the CNAs and licensed nurses throughout their shift. LVN 2 verified two gowns were hanging on the same hook. LVN 2 stated one gown should not be placed over another gown to avoid cross-contamination. On 9/8/2020 at 1242 hours, an observation of the facility's PPE inventory was conducted with the Central Supply Supervisor. The Central Supply Supervisor stated the facility did not have a shortage of PPE and had more than two-week worth of PPE. The Central Supply Supervisor stated the facility had approximately 350 washable gowns and 5,000 disposable gowns. The Central Supply Supervisor stated all laundry services, including of the washable gowns, were completed at the facility. On 9/8/2020 at 1313 hours, a telephone interview was conducted with the OCHCA's IP 1. The OCHCA's IP 1 stated reusing the gowns was not a good practice and not recommended due to the risk for cross-contamination. The OCHCA's IP 1 stated at the beginning of the pandemic when there was a dire shortage of PPE, it was okay to reuse the gowns, but the PPE supply chain had improved since. The OCHCA's IP 1 stated the OCHCA did not recommend reusing the gowns and the facility should not allow the staff to use the same gown for multiple residents. On 9/8/2020 at 1342 hours, an interview was conducted with the Administrator. The Administrator was asked if the facility was on contingency or crisis capacity for isolation gowns. The Administrator stated no. The Administrator verified the facility did not have a shortage of PPE. The Administrator was asked if the facility obtained prior approval from the OCHCA to reuse the gowns. The Administrator stated the OCHCA's IP 2 was aware of the facility reusing the gowns. On 9/8/2020 at 1550 hours, a telephone interview was conducted with the OCHCA's IP 2. The OCHCA's IP 2 was asked if the facility was given prior approval to reuse the isolation gowns. The OCHCA's IP 2 stated no and early on it was okay to reuse the gowns due to the severe shortage of PPE, but that was not the case now. The OCHCA's IP 2 stated it was previously recommended that the facility increased their supply of gowns. The OCHCA's IP 2 stated it was best practice for the gowns to be single-use to minimize outbreaks. 2a. On 9/8/2020 at 1110 hours, an interview was conducted with CNA 1. CNA 1 stated the staff were supposed to label the gowns with their name using the blue painter's tape and marker. On 9/8/2020 at 1122 hours, CNA 1 was observed in Room B removing her isolation gown then hanging it on the door of the residents' room. The gown was observed not labeled. CNA 1 verified the gown was not labeled. b. On 9/8/2020 at 1144 hours, Room C in the Yellow Zone was observed being occupied by two residents. Four washable gowns were observed hanging on the door of the residents' room. The isolation gowns were observed not

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555286	A. BUILDING _____ B. WING _____	**09/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW ORANGE HILLS	**5017 E. CHAPMAN AVENUE ORANGE, CA 92869**

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	(continued... from page 1) labeled. On 9/8/2020 at 1152 hours, an interview was conducted with LVN 2. LVN 2 stated the isolation gowns were supposed to be labeled to identify which gown belonged to which staff member. LVN 2 verified the four isolation gowns hanging on the door of Room C were not labeled. On 9/8/2020 at 1214 hours, an interview was conducted with the IP. The IP verified the staff were supposed to label their isolation gowns to prevent sharing of the gowns between staff members to prevent cross-contamination. 3a. Review of the facility's P&P titled How to Safely Remove Personal Protective Equipment Example 1 (undated) showed there are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. The outside of the gloves is contaminated. Remove the gloves before removing the gown. Remove the gown (with ungloved hands) by unfastening the gown ties and pulling the gown away from the body. On 9/8/2020 at 1119 hours, CNA 1 was observed in Room A assisting the resident. CNA 1 was observed with PPE donned. After assisting the resident, CNA 1 with soiled gloves proceeded to untie her isolation gown from behind her neck and removed the gown. CNA 1 hung the isolation gown, removed her gloves, and performed hand hygiene. CNA 1 acknowledged she should have removed her soiled gloves before removing her gown. b. On 9/8/2020 at 1147 hours, the washable isolation gown was observed hanging on the door handle of Room D in the Yellow Zone. The bottom portion of the isolation gown was observed touching and resting directly on the floor. On 9/8/2020 at 1149 hours, OT 1 was observed donning the washable isolation gown that was hanging on the door handle of Room D. OT 1 proceeded to assist a resident in the room. On 9/8/2020 at 1204 hours, OT 1 was observed in Room D with PPE donned. OT 1 was observed untying the strap of the isolation gown behind her neck with the soiled gloves still on. OT 1 proceeded to remove the gown with soiled gloves, then removed her soiled gloves. OT 1 verified the bottom portion of the isolation gown was resting directly on the floor before she donned it. OT 1 acknowledged the isolation gown should not have been resting directly on the floor and she should have removed her soiled gloves and performed hand hygiene prior to removing her isolation gown. On 9/8/2020 at 1300 hours, an interview was conducted with the DON. The DON verified the isolation gowns were not supposed to be hung on the door handles and were not supposed to be resting directly on the floor. The DON verified to safely remove PPE, the soiled gloves were supposed to be removed prior to untying and removing the isolation gowns to prevent cross-contamination. 4a. On 9/8/2020 at 1117 hours, an observation of the Yellow Zone was conducted. Room D was observed to have an Enhanced Droplet and Contact Precautions sign posted by the entrance of the room. The washable gowns were observed in the isolation cart by the entrance of the room. The room was observed to have three residents. Three staff were also in the room wearing the washable gown. RN 1 was observed taking off her washable gown, and hung it on the wall of the room. Two gowns were observed hanging on the wall with no label of the staff name on the gown. RN 1 stated each staff member had one washable gown that was reused for all residents in the same room throughout the entire shift, and the staff were supposed to label the gowns with their name. CNA 2 was observed providing care to Resident B. After finishing with Resident B, CNA 2 took off his gloves, sanitized his hands, and donned the clean pair of gloves. CNA 2 was then observed assisting Resident A to the bathroom. CNA 2 did not change the washable gown in-between care of these two residents. b. On 9/8/2020 at 1159 hours, an observation of Room E in the Yellow Zone was conducted. The room was observed with two residents. CNA 3 was observed providing care to Resident D. After he was done, CNA 3 was observed walking towards the next bed, closed the curtain, and provided assistance to Resident C. CNA 3 was then observed emptying the indwelling catheter bag of Resident D. CNA 3 was not observed performing hand hygiene nor changed her gown in-between care of two residents. CNA 3 verified the above findings. On 9/8/2020 at 1315 hours, an interview was conducted with the IP. When asked about using the washable gown for Enhanced Droplet and Contact Precautions in the Yellow Zone, the IP stated technically, the staff was supposed to change the washable gown for each resident in the Yellow zone. If the room had three residents, three sets of gown should be used and changed at the end of the shift.