STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055890	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAGNOLIA POST ACUTE CARE	635 S MAGNOLIA AVE EL CAJON, CA 92020

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, during a COVID- 19 (respiratory illness caused by coronavirus) infection control survey, the facility failed to ensure: 1. The COVID-19 Unit (section of the facility housing residents with active COVID-19 infections) consistently had dedicated (staff assigned only to a particular unit to reduce the possibility of spreading infection) licensed nurses (LNs) providing resident care. 2. Infection control barriers and assigned non-entry points remained closed. In addition, the infection control barriers and non-entry points lacked appropriate signage. These deficient practices had the potential to spread COVID-19 throughout the facility and infect residents and staff. Findings: 1. Resident 1 was readmitted to the facility on [DATE], per the facility's Admission Record. On 7/27/20 at 10:30 A.M., an interview was conducted with the facility's administrator (ADM), director of nursing (DON), and infection preventionist (IP). The ADM stated the facility currently had 40 residents with active COVID-19 infections out of a total census of 66 residents. The ADM stated there were nine staff members currently off duty for either testing COVID-19 positive or feeling unwell. The ADM stated the facility had a sufficient number of nursing staff and had not had to implement any staffing crisis strategies. The ADM stated when additional nursing staff were needed, the facility had been able to acquire nurses from the registry (agency providing nursing staff) as well as nurses from other facilities within the corporation. The DON stated there had been no problem staffing LNs. On 7/27/20 at 11:45 A.M., an interview was conducted with Resident 1 who resided in the North Yellow Zone (section of the facility housing residents with negative COVID-19 status and possible COVID-19 exposure). Resident 1 stated he had tested negative for COVID-19. Resident 1 stated he was concerned about becoming infected with COVID-19. Resident 1 stated the facility's night shift (11 P.M. to 7 A.M.) LNs were often assigned to provide care to both infected and uninfected residents. Resident 1 stated nursing staff assigned to the COVID-19 Unit were supposed stay on that unit during their entire shift. Resident 1 stated he had refused to receive care from LN 1 one night about a week ago because she had been caring for residents on the COVID-19 Unit. Resident 1 stated he was, afraid she'd give me COVID. On 7/27/20 at 12:39 P.M., an interview was conducted with LN 2. LN 2 stated nurses assigned to the COVID-19 Unit were dedicated to that unit and had to remain there during their entire shift. LN 2 stated nurses should not be providing care simultaneously to residents on both the COVID-19 Unit and the Yellow Zone. LN 2 stated doing so could spread COVID-19 between the units. On 7/27/20 at 1:23 P.M., an interview was conducted on the COVID-19 Unit with certified nursing assistant (CNA) 1. CNA 1 stated nursing staff assigned to the COVID-19 Unit had to remain on the unit, and were not allowed to provide care to residents on other units. CNA 1 stated this was done to prevent the spread of COVID-19. On 7/27/20 at 1:25 P.M., an interview was conducted on the COVID-19 Unit with LN 3. LN 3 stated LNs providing care to residents on the COVID-19 Unit were required to stay on the unit during their entire shift. LN 3 stated nurses were not allowed to provide care to residents in the Yellow Zone while working on the COVID-19 Unit. LN 3 stated this practice of dedicating staff to a unit prevented cross-contamination of COVID-19. LN 3 stated she did not think the facility had experienced any nursing staff shortages. On 7/27/20 at 2:56 P.M., a joint interview and record review was conducted with the DON. The DON reviewed the LNs room assignment schedule for June and July 2020 and stated the room assignment schedule was not an accurate reflection of the rooms nurses were actually assigned to. On 7/27/20 at 3:05 P.M., an interview was conducted with LN 1. LN 1 stated the facility set up a COVID-19 Unit in the beginning of June 2020. LN 1 stated the COVID-19 Unit was supposed to have dedicated nursing staff. LN 1 stated nursing staff assigned to the COVID-19 Unit were supposed to remain on the unit for their entire shift, and were not to leave the unit to provide care to residents on other units. LN 1 stated this was done to limit the risk of contaminating the other units with COVID-19. LN 1 stated the morning shift (7 A.M. to 3 P.M.) and evening shifts (3 P.M. to 11 P.M.) consistently had dedicated nursing staff on the COVID-19 Unit. LN 1 stated this was not consistently being done on the night shift. LN 1 stated it was harder to get nurses to work night shift. LN 1 stated there were times when she had worked the night shift and she was required to provide care to both the Yellow Zone residents as well as the COVID-19 Unit residents. LN 1 further stated she recalled the incident with Resident 1. LN 1 stated Resident 1 would not let her change his [MEDICAL CONDITION] (procedure to divert the colon to an opening in the abdomen for passage of feces) bag because he was aware she had returned to the Yellow Zone after providing care to residents on the COVID-19 Unit. LN 1 stated she was not sure why the facility had not converted to 12-hours shifts or other methods to provide consistent and dedicated night shift LNs on the COVID-19 unit. On 7/27/20 at 3:40 P.M., an interview was conducted with the facility's IP. The IP stated best practice to reduce the potential spread of COVID-19 was to dedicate nursing staff on all shifts on the COVID-19 Unit. The IP stated having night shift LNs provide care to both the Yellow Zone and COVID-19 Unit had increased the risk of spreading COVID-19. The IP stated the facility should have consistently provided dedicated staff to the COVID-19 Unit. On 7/27/20 at 4 P.M., an interview was conducted with the DON. The DON stated there had been times when night shift LNs provided care to residents on both the Yellow Zone and COVID-19 Unit. The DON stated this was not the best infection control practice. The DON stated dedicated LNs should have been consistently provided on the COVID-19 Unit for all shifts. According to the CDC (Centers for Disease Control), 4/30/20, Responding to Coronavirus (COVID-19) in Nursing Homes .Establishing a designated COVID-19 care unit for residents with confirmed COVID-19 . Assign dedicated HCP (health care providers) to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents Per the facility's undated policy titled Infection Control and Prevention Policy Emerging Infectious Disease (EID): Coronavirus Disease 2019 (COVID-19), .Facilities should consider caring for these patients with dedicated HCP to minimize risk of transmission and exposure to other patients an other HCP 2. On 7/27/20 at 11:03 A.M., during an interview in the main dining hall with the facility's administrator (ADM), director of nursing (DON), and infection preventionist (IP), a staff member was observed opening the double doors leading into the dining hall. The ADM was observed educating the staff member to remain in the unit and to close the doors. On 7/27/20 at 12:20 P.M., a joint observation and interview was conducted with the DON on the South Yellow Zone (section of the facility housing residents with negative COVID-19 status and possible COVID-19 exposure). A semi transparent plastic barrier was set up in the hallway, covering ceiling to floor and wall to wall, and with zippers down the middle, separated the Yellow Zone from the Covid-19 Unit (section of the facility housing residents with active COVID-19 infections). A staff member on the COVID-19 Unit was observed opening the plastic barrier by the zipper and poking their head through into the Yellow Zone. The staff member hurriedly retreated back to the COVID-19 Unit. There was no signage posted indicating whether or not the barrier could be accessed. The DON stated she was unsure who the staff member was. The DON stated no one should have opened the plastic barrier separating the units. The DON stated opening the plastic barrier could lead to cross-contamination of COVID-19 and risk spreading infection into the Yellow Zone. The DON further stated there should have been signs posted on both sides of the barrier to indicate the barrier was not to be opened. Further observation on the unit revealed a set of solid double doors leading to the dining hall. The double doors were devoid of any signage. The DON stated the double doors were not to be opened. The DON stated there should have been appropriate signs posted on the double doors to bar entry or exiting. On 7/27/20 at 1:10 P.M., a joint observation and

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) interview was conducted with the DON on the South COVID-19 Unit. The solid double doors leading to the reception area were devoid of any signage. The DON stated the double doors had to remain closed. The DON further stated there should have been appropriate signage to indicate the double doors were not to be opened. On 7/27/20 at 2:30 P.M., an interview was conducted with the ADM and IP. The ADM stated all plastic barriers between units, and doors not designated for entry or exit to the units, should not have been opened. The ADM stated poking heads through the plastic barriers was unacceptable. The ADM stated all barriers, and doors not designated for entry or exit, should have had appropriate signage to indicate they were not to be opened. The facility's undated policy titled Infection Control and Prevention Policy Emerging Infectious Disease (EID): Coronavirus Disease 2019 (COVID-19), did not provide guidance related to physical barriers between units and non-designated entries and exits.